DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	**2081 LANGHORNE ROAD** **LYNCHBURG, VA 24501**

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2/20/18 through 2/23/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/20/18 through 02/23/18. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Seven complaints were investigated during the survey. The census in this 120 certified bed facility was 98 at the time of the survey. The survey sample consisted of 24 current Resident reviews and 8 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		4/4/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/15/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and in the course of a complaint investigation the facility failed to promote dignity for 3 of 32 residents in the survey sample, Residents, #297, #38, and #74. 1. A trash bag was substituted for a colostomy bag for Resident #297 (R 297). 2. Resident #38 had care instructions posted on the wall. 3. Resident #74 (male Resident) was sharing a	F 550	1. a. Resident #297 is no longer a resident in our facility. b. Care instructions posted on wall for resident #38 have been removed. c. Locks will be installed on the bathroom doors for resident #74 to assure for privacy. 2. a. An audit of all residents with orders for a colostomy was completed by Director of Nursing (DON) and designees on 3/13/2018 to ensure dignity is provided	

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F 550	Continued From page 2 bathroom with a female Resident without interventions in place to allow for privacy. The Findings Include: 1. R 297 was admitted to the facility on 4/12/17. An initial MDS (Material Data Set) with an ARD (Assessment Reference Date) of 4/19/17, indicated that R 297 was cognitively intact with a score of 13 of 15 with a diagnoses of a colostomy. During a complaint investigation conducted on 2/21/17, R 297 record review indicated that R 297 was admitted on 4/12/17 and discharged on 4/26/17. This was a closed record investigation. The complainant was contacted and interviewed on 2/21/18 at 10:40 AM regarding the allegation of R 297 being discharged to another facility and upon discharge, the facility used a trash bag substituted for a colostomy bag and was sent to another entity wearing the trash bag. The complainant verbalized that when R 297 arrived at the facility where he was being transported to, R 297 was mortified over the experience, verbalizing he was not going back to the facility where he came from as they did not have supplies for his colostomy. On 2/21/18 at 11:30 AM the director of nursing (DON) was interviewed concerning colostomy supplies for the facility. The DON verbalized that the facility did have supplies at the time, but the agency nurse did not know where the colostomy bags were located and put a trash bag on R 297. The central supply manager was also in the room	F 550	always. No additional dignity issues were identified. b. A facility wide audit was conducted on 3/13/2018 by Executive Director to ensure that no additional resident care instructions were posted on walls. All identified issues were corrected. c. A facility wide audit of patient bathrooms was completed on 3/13/2018 by maintenance personnel to ensure bathroom doors allow for privacy. All identified issues will be corrected. 3. a. Inservices for Licensed Nursing Staff were initiated on 3/8/2018 in-serviced by DON and designee regarding ensuring dignity for residents with colostomy bag by utilizing appropriate medical supplies. An audit of all residents with orders for a colostomy bag will be completed three times a week for a period of 30 days by facility DON or designee to ensure dignity is maintained. b. Inservices for facility staff were initiated by DON and designees on 3/8/2018 regarding the posting of care instructions on walls. A facility audit to be completed three times a week for a period of 30 days by facility DON or designee to ensure that care instructions are not posted on walls of patient rooms. c. Maintenance personnel have been educated by facility Executive Director regarding bathroom doors having appropriate mechanisms to assure for resident privacy. A weekly audit of facility bathroom doors to be completed for a period of 30 days by maintenance personnel to ensure patient bathrooms	

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F 550 Continued From page 3

when this surveyor was talking with the DON and was asked to provide documentation evidencing the colostomy bags were in the facility at the time of the incident.

The central supply manager was able to provide documentation that colostomy supplies were in the facility at the time of the incident and are ordered on a regular basis.

On 02/23/18 07:39 AM this surveyor talked with the administrator regarding resident's feelings about having a trash bag act as a colostomy bag, the administrator agreed that he would feel mortified also. The administrator also verbalized that the agency staff have all been orientated of where to find supplies or to ask other staff personal.

No other information was provided prior to exit conference on 2/23/18.

This is a complaint deficiency.

2. Care instructions regarding eating/swallowing were posted on the wall in Resident #38's room. The instructions included the resident's name and were visible to anyone entering the room.

Resident #38 was admitted to the facility on 5/25/17 with a re-admission on 12/11/17. Diagnoses for Resident #38 included high blood pressure, diabetes, seizures, bipolar disorder, pneumonia and depression. The minimum data set (MDS) dated 12/21/17 assessed Resident #38 as cognitively intact.

On 2/21/18 at 10:12 a.m., Resident #38 was

F 550

allow for privacy.
4. The results of all audits will be brought to monthly Quality Assurance and Performance Improvement committee for review and recommendations as the committee determines.

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F 550 Continued From page 4 F 550

observed in his room. Posted on the wall between the window and the television was a handwritten poster that included the resident's name and eating/swallowing instructions. The poster stated the following:

SAFE SWALLOW TECHNIQUES
1. Sit up at 90 degrees when eating.
2. Take small bites one at time.
3. Clear mouth before taking next sip of liquid.
4. Clear throat every 3rd bite and re-swallow...hard!
5. Stay up for 30 minutes following meals.

On 2/21/18 at 10:16 a.m., the licensed practical nurse (LPN #3) caring for Resident #38 was interviewed about the posted care instructions. LPN #3 stated the resident was in speech therapy several months ago and thought therapy may have posted the instructions.

On 2/22/18 at 9:45 a.m., the therapy director was interviewed about the posted swallowing instructions for Resident #38. The therapy director stated the speech therapist was in the facility three times per week. The therapy director stated, "That [posted instructions] could be something speech posted." The therapy director stated individual care instructions were supposed to be laminated and posted inside the resident's closet door. The therapy director stated care instructions were not supposed to be posted on walls for everyone to see.

These findings were reviewed with the administrator and director of nursing during a meeting on 2/22/18 at 5:25 p.m.

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F 550	Continued From page 5	F 550		

3. The facility staff failed to ensure the dignity of Resident # 74 for privacy while toileting; the resident shared an adjoining bathroom with the opposite sex and the bathroom did not have locks for privacy.

Resident # 74 was admitted to the facility on 11/07/17. Diagnoses included, but were not limited to: insomnia, thrombocytopenia, CHF (congestive heart failure), anemia, and muscle weakness.

The most current MDS (minimum data set) was a quarterly assessment dated 02/01/18. This MDS assessed the resident with a cognitive score of 15, indication the resident is cognitively intact for daily decision making skills. The resident was also assessed as requiring minimal assistance from staff for most ADL's (activities of daily living) including toileting.

On 02/22/18 at 09:14 AM, Resident # 74 voiced concerns regarding a single toilet restroom that adjoins with two resident of the opposite sex. The resident stated that when the shared bathroom is occupied with a resident on the other side, there is no way of really knowing if anyone is the bathroom, because there are no locks on the door for privacy. The resident stated that the bathroom was accessed this morning, while the other resident was in there and that the other resident was 'terribly upset.'

On 02/22/18 at 09:29 AM The shared bathroom was accessed from Resident # 74's side, the bathroom had a call bell panel (resembling a light switch cover) with a slide button to turn off the call

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F 550	Continued From page 6	F 550		

bell, once accessed. The bathroom did not have a pull cord, for residents to pull while in the restroom (if assistance was needed).

On 02/22/18 at 09:57 AM the shared bathroom was accessed from the other room. A resident in that room stated that the only thing that is an issue, is that the residents in the other room get urine on the floor and then you have to walk in it.

02/22/18 04:13 PM, the AC (Admission Coordinator) was interviewed and stated that she has been in this role for 3 years. The AC stated that two of the residents in room 35 had both been in different room when they were first admitted and she was not sure the exact date of when they went into that room. The AC stated that it is usually a consensus as to what room residents are changed to and that would be between herself (admissions) and nursing and then stated, "It is usually me." The AC stated that we (the facility) have several rooms that are boy/girl...Jack and Jill bathrooms is what we call them, that are shared bathrooms. The AC stated, "I know we can't lock the bathroom, I know when the nurses take the resident's to the bathroom if they are independent, they shut the door." The AC was asked how does this ensure a resident's privacy and dignity if the resident can take themselves to the bathroom and then can't lock and someone walks in on them. The AC stated, "They can knock on the door, if they take themselves." The AC stated that we (the facility) have several rooms that share a bathroom, so it isn't a concern if they (the residents) are not able to use the bathroom by themselves (meaning nursing takes them). The AC stated, "As far as I know, when it (that room match up) went into effect I wasn't sure that he (Resident # 74) could

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F 550	Continued From page 7 take himself to the restroom. A policy was requested on sharing a single unit bathroom with opposite genders and on bathroom locks. The AC stated that she wasn't sure if they have a policy. 02/22/18 04:42 PM The AC stated that we do not have a Jack and Jill policy, we do our best to ensure privacy and make sure females and males have privacy-sometimes it ends up being males on one side and females on the other unfortunately and we do not have a policy, other that to keep the doors shut while the bathroom is occupied and we don't have locks. On 02/22/18 at 5:15 p.m. the administrator and DON (director of nursing) were made aware of the above information. No further information and/or documentation was presented prior to the exit conference on 02/23/18 at 12:45 p.m.	F 550		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, the Group Interview, and staff interview, the facility failed to accommodate the activity needs of one of 32 residents in the survey sample (Resident # 39), and failed to accommodate the	F 558	1. a. Resident #39 has been met with and educated that she is permitted to go on activity trips and use the court yard during periods when residents and visitors are	4/4/18

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F 558 Continued From page 8

television needs, and personal refrigerator needs of the facility residents.

Resident # 39 said she was not allowed to go on activity trips or to the Court Yard because of her oxygen use. During the Group Interview the residents complained that television reception in the facility was unacceptable. The residents in the Group Interview also complained that personal refrigerators had been removed from their rooms.

The findings were:

1. Resident # 39 stated she was unable to go on Activity trips or use the Court Yard because of her oxygen use.

Resident # 39 in the survey sample, a 65 year-old female, was admitted to the facility on 4/27/17, and most recently readmitted on 9/19/17 with diagnoses that included dyspnea, chronic respiratory failure with hypoxia and hypercapnia, chronic obstructive pulmonary disease with exacerbation, generalized muscle weakness, systemic inflammatory response syndrome, anxiety disorder, hypokalemia, and shortness of breath. According to the most recent Minimum Data Set, a Quarterly with an Assessment Reference Date of 12/14/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Resident # 39 had an order for, "O2 (Oxygen), may titrate between 4 - 6 L (liters) via oxygenizer to maintain (oxygen) sats (saturation) above 90%. (NOTE: AN oxygenizer is disk placed in the oxygen line to enhance the amount and flow of

F 558

not smoking. Resident verbalized understanding and had no further concerns.

b. Vendor who supports facility television was contacted during survey process. Multiple connection boxes were replaced by vendor and reception has improved. Facility has begun contacting new vendors for proposals for potential replacement.

c. Resident Nourishment room to be created for residents wishing to store labeled personal food items in a secured full-size refrigerator.

2. All residents have potential to be affected.

3. A Resident Council meeting was held on 3/12/2018 to explain/address Group Interview concerns and plans to address the concerns going forward. Residents verbalized that television reception has greatly improved since facility actions taken and gratitude expressed by residents regarding created ability to store personal, labeled and dated food in a secured refrigerator. Activities personnel to discuss issues with residents on a weekly basis for a period of 30 days regarding reasonable accommodations of needs/preferences.

4. The results/concerns expressed at these meetings will be brought to monthly Quality Assurance and Performance Improvement meetings for review and discussion and any modifications as indicated.

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F 558 Continued From page 9 | F 558

oxygen.)

During the Group Interview at 1:30 p.m. on 2/21/18, the residents were asked about Activity trips to go shopping or out to other activities. During the discussion, Resident # 39 said she was not allowed to go on trips or to go out to the Court Yard.

In a private interview after the Group Interview, Resident # 39 said she was not allowed to go on trips because of her oxygen use. Asked if taking extra oxygen tanks would allow her to go, the resident said, "They told me they can't take extra tanks." Resident # 39 also said she wasn't allowed to go out in the Court Yard. Asked why, the resident said, "It's because of the smokers and my oxygen. I can go out and sit on the porch in front of the building with my friends, but I can't go to the Court Yard. There is a sign at the door to the Court Yard that says oxygen isn't allowed out there."

(NOTE: Resident # 39 was unable to stay for the entire Group Interview without leaving to replace her oxygen tank when the one in use ran low.)

At the door leading out to the Court Yard, a sign bearing the following message was posted next to the door:

"Designated Smoking Area
No Oxygen Tanks
Beyond This Point
Please ask a staff member for assistance and remove the oxygen tank from your chair. Place the oxygen tank in the holder provided for you beside the door.
Thank you!

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F 558	Continued From page 10	F 558		

At 3:30 p.m. on 2/22/18, the Activities Director was interviewed regarding Resident # 39 being unable to go on trips due to her oxygen use. "She can go on trips," the Activities Director said, "but it would have to be a very short trip. We can only take one oxygen tank with us. When she runs out, she needs it right away." Asked if they could take more than one tank, the Activities Director said, "No"

During an end of day meeting at 4:00 p.m. on 2/21/18, that included the Administrator, Director of Nursing, and the survey team, Resident # 39's complaint of not being able to go on trips or use the Court Yard was discussed. The Administrator said there was a misunderstanding regarding the sign and the use of the Court Yard, and that he would change the sign. As of 10:30 a.m. on 2/22/18, the sign at the door to the Court Yard was unchanged.

2. During the Group Interview the residents complained that television reception in the facility was unacceptable.

Prior to the Group Interview a review of the minutes from recent Resident Council meetings revealed an ongoing problem with television reception. During the Group Interview, the residents were asked if there had been any improvement in the reception.

"It's a joke," said one resident. "They need to have a new system." Another resident said, "The Activities Room has (name of television provider) and the reception is okay. The rest of the facility has (name of television provider) and the

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F 558	Continued From page 11	F 558		

reception is terrible."

Resident # 28, who was also in attendance at the Group Interview, said, "I only get two channels, and the rest are just blue screens." During a review of the resident's care plan for Activities, the following intervention was noted, "When he chooses not to participate in organized activities encourage him to turn on TV or music in room to provide sensory stimulation."

During an end of day meeting at 4:00 p.m. on 2/21/18, that included the Administrator, Director of Nursing, and the survey team, the matter of television reception was discussed. According to the Administrator, the television service in the facility is provided by a third party vendor. The Administrator went on to say there is a box for each channel and they (the facility) have been waiting for several months for the boxes to be replaced.

At 9:00 a.m. on 2/23/18, the Maintenance Director spoke to the survey team regarding television reception. He reiterated the Administrator's statements regarding the third party vendor and the need to replace channel boxes. The Maintenance Director went on to say that, "The system is analog, and everyone (service providers) has changed to digital. I've been working on this for several months and we keep getting put off. There is only one technician in the area to provide help for us."

3. The residents in the Group Interview complained that personal refrigerators had been removed from their rooms.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 12 Asked if there were any other matters to discuss during the Group Interview, the residents said that personal refrigerators had been removed from their rooms. Asked why they were removed, one resident said, "They told us it was a fire hazard." Another resident stated, "My daughter was going to bring me one, but then they took them all out so she didn't bother." During the end of day meeting at 4:00 p.m. on 2/21/18, that included the Administrator, Director of Nursing, and the survey team, the removal of personal refrigerators was discussed. Told the resident said they were told the refrigerators were a fire hazard, the Administrator said, "No. It was an infection control issue." Asked if there was someplace the residents could store snacks and food items that needed refrigeration, the Administrator said they could be kept in the refrigerator in the medication room at the Nurse's Station." When asked if the residents had free access to the refrigerators, the Administrator said, "They would need to ask for access."	F 558		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		4/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 13 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, group interview and clinical record review, the facility staff failed to maintain a clean, safe and homelike environment for one of 32 residents in the survey sample and on one of five units. Resident #37's wheelchair was in disrepair. Resident furniture, walls and window blinds were in disrepair in multiple rooms on unit II and failed to accommodate the television needs in the facility.	F 584	1. a. Right and left arm rests on wheelchair for resident #37 have been replaced by maintenance personnel. b. bedside tables in rooms 42-A, 47-A, and 41-B have been replaced. Maintenance personnel completed wall repair to room 49A in identified area. Blinds in 42-A have been repaired. c. Television station vendor has made	

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	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 584

Continued From page 14

1. The failed to ensure Resident # 37's w/c was in good repair, the armrest was missing and the covering of the left armrest was cracked with exposed foam visible.

2. Resident furniture, a wall and window blinds were in disrepair in multiple rooms on unit II.

3a. During personal resident interviews, individual residents complained regarding the poor television reception in the facility.

3b. During the Group Interview residents complained that television reception in the facility was unacceptable.

The findings include:

1. Resident #37's wheelchair was in disrepair. The right armrest was missing and the covering of the left armrest was cracked with exposed foam visible.

Resident #37 was admitted to the facility on 7/1/15 with diagnoses that included kidney failure, dementia with behaviors, protein-calorie malnutrition, mood disorder and depression. The minimum data set (MDS) dated 12/27/17 assessed Resident #37 with severely impaired cognitive skills.

On 2/20/18 at 3:30 p.m., Resident #37 was observed in her wheelchair, propelling in the hallway. The right armrest on the wheelchair was missing with the resident's forearm resting directly against the chrome support bar. The covering on the left armrest was cracked with yellow foam visible.

F 584

repairs to existing system and reception has improved and is acceptable to residents per resident feedback to facility leadership at a meeting with the residents on 3/12/2018.

2.
a. Audit of all wheelchairs to be completed by maintenance personnel. All identified issues to be addressed.
b. Facility wide audit of furniture, walls, and blinds to be completed by maintenance personnel. All identified issues to be addressed by the maintenance staff.
c. All residents have potential to be affected by poor television reception.

3. Facility staff have been in-served by DON and designee regarding the timely alerting of maintenance personnel regarding necessary repairs to wheelchairs, furniture, walls, and blinds using the automated work order system via TELS. Resident Council meeting was held on 3/12/2018 to alert residents to recent repairs to television station reception system. Facility tours are to be completed on weekly basis by maintenance personnel for a period of 30 days to ensure wheelchairs, furniture, walls, and blinds are maintained in good repair and to ensure televisions have good reception.

4. Collected compliance data from facility tours will be brought to monthly facility Quality Assurance and Performance Improvement for review and revisions as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	**2081 LANGHORNE ROAD LYNCHBURG, VA 24501**

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F 584	Continued From page 15	F 584		

On 2/22/18 at 9:20 a.m. accompanied by the maintenance director, Resident #37's wheelchair was observed with the missing armrest and cracked armrest cushion. The maintenance director stated work orders were supposed to be entered for any equipment items needing repair. The maintenance director stated he was not aware the wheelchair was in disrepair.

On 2/22/18 at 10:25 a.m. the licensed practical nurse (LPN #3) caring for Resident #37 was interviewed about the wheelchair in disrepair. LPN #3 stated she did not realized the armrest was missing. LPN #3 stated nurses were responsible for sending work orders to maintenance when repairs were needed.

These findings were reviewed with the administrator and director of nursing during a meeting on 2/22/18 at 5:25 p.m.

2. Resident furniture, a wall and window blinds were in disrepair in multiple rooms on unit II.

On 2/20/18 at 10:47 a.m., the over-bed table in room 47-A was observed. The protective edging was missing around the outer edge of the table with particle board visible.

On 2/20/18 at 11:10 a.m. room 49-A was observed with poor wall repair around the heat/ac unit near the window. The wall repair around the ac/heat unit and the electrical outlet box under the window was rough with an uneven surface. Spackling was visible with sections of the wall not painted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	**2081 LANGHORNE ROAD** **LYNCHBURG, VA 24501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 16	F 584		

On 2/20/18 at 12:01 p.m. the bedside table in room 42-A was observed in disrepair. The finish around the entire edging of the table was worn with multiple scratches/dents to the table. Two of the vertical slats on the window blinds were missing in room 42-A leaving approximately a 6 inch gap in window coverage when closed.

On 2/20/18 at 12:06 p.m. the over-bed table in room 47-A was observed with one corner of the edging separated and hanging from the table. Particle board was exposed in the section with the missing edging.

On 2/20/18 at 12:07 p.m. the over-bed table in room 41-B was observed with the edging cracked. In the floor near the head of the bed was a wheelchair leg rest, empty cup with straw and a Christmas stocking.

On 2/22/18 at 9:20 a.m., accompanied by the maintenance director, the above items were observed. The maintenance director stated staff members were supposed to enter work orders for items needing repair. The maintenance director stated he did not have work orders on the above listed items.

These findings were reviewed with the administrator and director of nursing during a meeting on 2/22/18 at 5:25 p.m.

3a. During personal resident interviews and during the Group Interview, residents complained that television reception in the facility was unacceptable.

Resident #7 was interviewed on 02/20/18 at 11:30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 17	F 584		

a.m. Resident #7 stated, "My TV is broken. I only get channels 13 and 15. It has been broken for at least 6 weeks. I was told they have to come from Florida to fix it according to the head maintenance guy." During the survey conducted 02/20/18 through 02/23/18 the survey team identified several rooms with broken tv's or tv interference causing distortion of the tv picture. The rooms and resident identifiers are as follows: 46-A R#83, 42-A R#19, 47-A R#60; 45-A R#28; 61-A R#61, 24-B R#79; 5-B R#7, 15-B R#79; and 38-B R#18.

The Director of Maintenance was interviewed on 02/22/18 at 11:15 a.m. The Director stated, "We have been working on the television situation for at least six months. The problem is our service is through a third party vendor that is in another state. They only have one service tech (technician) in our area. We have been on the list several times and keep getting bumped further down the list because the rep [tech] gets busy on other jobs. We have analog tv and of course everything is now digital. We have individual boxes for each channel. We have been glowing back and forth with the company and corporate for at least six weeks."

3b. During the Group Interview residents complained that television reception in the facility was unacceptable.

Prior to the Group Interview a review of the minutes from recent Resident Council meetings revealed an ongoing problem with television reception. During the Group Interview, the residents were asked if there had been any improvement in the reception.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 584	Continued From page 18	F 584		

"It's a joke," said one resident. "They need to have a new system." Another resident said, "The Activities Room has (name of television provider) and the reception is okay. The rest of the facility has (name of television provider) and the reception is terrible."

Resident # 28, who was also in attendance at the Group Interview, said, "I only get two channels, and the rest are just blue screens." During a review of the resident's care plan for Activities, the following intervention was noted, "When he chooses not to participate in organized activities encourage him to turn on TV or music in room to provide sensory stimulation."

During an end of day meeting at 4:00 p.m. on 2/21/18, that included the Administrator, Director of Nursing, and the survey team, the matter of television reception was discussed. According to the Administrator, the television service in the facility is provided by a third party vendor. The Administrator went on to say there is a box for each channel and they (the facility) have been waiting for several months for the boxes to be replaced.

At 9:00 a.m. on 2/23/18, the Maintenance Director spoke to the survey team regarding television reception. He reiterated the Administrator's statements regarding the third party vendor and the need to replace channel boxes. The Maintenance Director went on to say that, "The system is analog, and everyone (service providers) has changed to digital. I've been working on this for several months and we keep getting put off. There is only one technician in the area to provide help for us."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 584 Continued From page 19 F 584

No further information was received by the survey team prior to the exit conference on 02/23/18.

F 641 SS=D Accuracy of Assessments
CFR(s): 483.20(g) F 641 4/4/18

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate MDS (minimum data set) for two of 32 residents in the survey sample, Resident # 95 and Resident # 7.

1. The facility staff failed to accurately assess Resident # 95 regarding a discharge (return not anticipated) MDS (minimum data set). The resident was discharged home, not to the hospital as indicated on the MDS.

2. Facility staff failed to document an accurate MDS (minimum data set), Section M - Skin Conditions, for Resident #7.

Findings include:

1. The facility staff failed to accurately assess Resident # 95 regarding a discharge (return not anticipated) MDS (minimum data set). The resident was discharged home, not to the hospital as indicated on the MDS.

Resident # 95 was admitted to the facility on 12/20/17, with diagnoses including, but not limited

Provider's plan of correction:

1.
a. MDS for resident #95 has been corrected.
b. MDS for resident #7 has been corrected.
2.
a. An audit of all discharges for the past 30 days was completed on 3/14/2018 by MDS personnel to ensure for accurate coding of discharge destination. No other issues identified.
b. An audit of all quarterly MDS of current residents for the past 30 days was completed on 3/14/2018 by MDS personnel to ensure accurate coding of Section M.
3. Facility MDS personnel in-serviced on 3/14/2018 by Regional MDS Specialist regarding accurate coding of discharges and Section M. MDS personnel to audit all discharge and quarterly MDS for a period of 30 days to ensure accurate coding.
4. Results of audit to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 20	F 641		

to: COPD, emphysema, tobacco use, constipation, MDD (major depressive disorder), anxiety, pain and oxygen dependence.

The most current full MDS (minimum data set) with CAAS (care area assessment summary) for Resident # 95 was the admission assessment dated 12/27/17. This MDS assessed the resident with a cognitive score of 14, indicating the resident was intact for daily decision making skills. The resident was not triggered for return to community in the CAAS section.

The resident's discharge MDS RNA (return not anticipated) was reviewed dated 01/03/18 documented that the resident was discharged on 01/03/18. The MDS additionally documented the discharge as unplanned, and that the resident went to an acute care hospital.

During clinical record review on 02/22/18 11:17 a.m., the clinical record revealed in the nursing notes that the resident was discharged home. Further review of the clinical record revealed that Resident # 95 was a PACE Medicaid resident and it was documented throughout the nursing notes that the resident was planning and wanting to return home soon.

The resident's CCP (comprehensive care plan) was then reviewed and did not address the resident's discharge plan. Physician's progress notes from the facility did not document the residents discharge in any way. There was no information indicating if this was a planned discharge.

The administrator and DON (director of nursing) were made aware of the above information in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 641 Continued From page 21

F 641

meeting with the survey team on 02/22/18 at the end of the day. The administrator stated that the resident was a PACE patient and that the resident was only here (at facility) for respite care and that PACE handled everything for the resident. The administrator stated the resident went home on 01/03/18. The administrator and DON were made aware that the resident's clinical record did not address any of the information provided.

On 02/23/18 at approximately 7:31 a.m., the MDSC (minimum data set coordinator) was interviewed regarding Resident # 95 and was asked where the information for Resident # 95 came from (discharge unplanned and discharge to hospital). The MDSC stated that she didn't know where she got the information. The MDSC was then asked for assistance in locating any information on this resident. The MDSC then stated that this information (on the MDS RNA) was coded in error, the resident did not go to the hospital and he was a planned discharge and that she would make a correction.

No further information and documentation was provided prior to the exit conference on 02/23/18 at 12:45 p.m.

2. Facility staff failed to document an accurate MDS (minimum data set), Section M - Skin Conditions, for Resident #7.

Resident #7 was originally admitted to the facility on 08/14/12 and readmitted on 08/01/13 with diagnoses including, but not limited to: COPD (chronic obstructive pulmonary disease), Depression, Anxiety, Chronic Pain, CHF

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 22	F 641		

(congestive heart failure) requiring continuous oxygen use, and Protein-Calorie Malnutrition.

The most recent MDS was a quarterly assessment with an ARD (assessment reference date) of 02/14/18. Resident #7 was assessed as cognitively intact with a total cognitive score of 14 out of 15.

Resident #7's clinical record was reviewed on 02/22/18 at 8:30 a.m. During this review a nursing progress note dated 01/28/18 included the following documentation, "...3rd toe left foot which has been red at knuckle now has a yellow area surrounding. Placed on NP [nurse practitioner] board for evaluation..." A weekly wound note dated 01/30/18 included the following, "...the left second toe [sic] [actually third toe] is noted with an open area 1 cm x 0.9 cm x 0.2 cm. the wound bed is dark with a hard scab in center with a swollen white pocket around scab. [sic] there is a moderate amount of purulent drainage and the toe is red and swollen. [sic] The patient stated the area is painful to the touch..."A nursing skin observation note dated 02/03/18 included, "A skin observation was completed...infection from podiatry on keflex [sic]..." A weekly wound documentation note dated 02/06/18 included the following, "...infected left third toe. Assessment: An open area continues on the left third toe 0.8 cm x 0.5 cm x 0.1. [sic] The wound bed is 90% scabbed and 10% pink epithelial tissue. There is a small amount of serous exudate with some redness that continues around the wound edges..."

The quarterly MDS assessment dated 02/14/18 did not include this foot wound on the assessment under Section M - Skin Conditions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	**2081 LANGHORNE ROAD LYNCHBURG, VA 24501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 23 The MDS nurse was interviewed on 02/22/18 at 3:10 p.m. regarding the above information. The MDS nurse and this surveyor looked at said MDS together and the MDS nurse stated, "Oh, I will have to correct that." The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 02/22/18 at 5:25 p.m. No further information was obtained prior to the exit conference on 02/23/18.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F 655		4/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 655 Continued From page 24

(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, and clinical record review, facility staff failed to formulate an initial care plan for the care of a central venous catheter (central line).

Facility staff failed to formulate an initial care plan for the care and maintenance of a central line.

Findings included:

Resident #43 was originally admitted to the facility on 01/31/18 and readmitted on 02/08/18 with diagnoses including, but not limited to: Endocarditis, Infection caused by an implantable cardiac device, Protein/Calorie Malnutrition, Dementia, Depression, Anxiety and Stage 4 Pressure Ulcer.

The most recent MDS (minimum data set) was

F 655

1. A care plan for central line has been created. Resident #43 was hospitalized and central line removed on 3/3/18. Care plan for central line has been resolved.
2. An audit of all residents with a central line was completed by MDS on 3/13/2018 to ensure initial care plan for care has been formulated. No further issues identified.
3. Inservices for Licensed Nursing staff was initiated on 3/14/2018 regarding formulation of initial care plans for central line. A weekly audit to be conducted by DON or designee for a period of 30 days to ensure initial care plans are formulated for the central line care.
4. Results of audit to be brought to monthly Quality Assurance and Performance Improvement meeting for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 25	F 655		

an initial assessment with an ARD (assessment reference date) of 02/15/18. Resident #43 was assessed as moderately impaired in his cognitive status with a total cognitive score of 10 out of 15.

Resident #43 was interviewed on 02/21/18 at 10:45 a.m. Resident #43 stated he was receiving antibiotics via a central line IV (intravenous) catheter three times a day. The resident proceeded to show this surveyor the central line located in his right chest wall.

Resident #43's clinical record was reviewed on 02/20/18 at approximately 2:00 p.m. During this review the following physician orders were noted, "...Cefazolin Sodium Solution Reconstituted 1 GM [gram] Use 2 gram intravenously every 8 hours for infection...Order Date/Start Date 02/21/2018...Normal Saline Flush Solution (Sodium Chloride Flush) Use 3 cc [cubic centimeters] intravenously before and after iv meds for iv abts [antibiotics] before and after iv meds..." There was no physician orders for the care and maintenance of the central venous catheter other than the prescribed medication orders.

Subsequent review of the initial care plan did not include any focus areas or interventions pertaining to the care and maintenance of a central venous catheter or for the administration of IV antibiotics and saline flushes.

The DON (director of nursing) was interviewed on 02/22/18 at approximately 2:10 p.m. regarding Resident #43's care plan for his central line and IV antibiotics. The DON stated, "MDS does the care plans. They run MD orders everyday and update the care plans. On the weekends, they

Provider's plan of correction (continued): review and revisions as the committee determines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 655	Continued From page 26 run orders on Monday mornings and update." This surveyor and the DON reviewed Resident #43's care plan. The DON stated, "That sounds like a peripheral IV care plan," then shook her head. The Administrator was apprised of the above findings during a meeting with the survey team on 02/22/18 at approximately 5:25 p.m. No further information was received by the survey team prior to the exit conference on 02/23/28.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		4/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 656	Continued From page 27 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to develop and implement a CCP (comprehensive care plan) for 4 of 32 residents in the survey sample, Resident # 95, 83, 39 and 43. 1. The facility staff failed to develop a CCP (comprehensive care plan) for Resident # 95 for discharge/return to community. 2. Resident #83 had no plan of care developed concerning positioning related to impaired range of motion of her lower extremities. 3. Facility staff failed to develop a care plan to address the use of a BiPAP machine for Resident # 39. 4. Facility staff failed to develop a CCP for care of a central venous catheter for Resident #43.	F 656	1. a. Resident #95 has been discharged from the facility. b. For Resident #83, the care plan has been modified to address concerns of positioning related to impaired range of motion to her lower extremities. c. For Resident #39, the care plan has been modified to address the use of a BiPAP machine d. care plan for central line for Resident #43 was created. Resident was hospitalized and central line removed on 3/3/2018. Care plan has been resolved 2. a. An audit all residents was initiated on 3/14/2018 by facility Social Services Director to ensure each resident has a care plan regarding potential for discharge/return to the community. All identified issues will be corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 656

Continued From page 28

Findings include:

1. The facility staff failed to develop a CCP (comprehensive care plan) for Resident # 95 for discharge/return to community.

Findings include:

Resident # 95 was admitted to the facility on 12/20/17, with diagnoses including, but not limited to: COPD, emphysema, tobacco use, constipation, MDD (major depressive disorder), anxiety, pain and oxygen dependent.

The most current full MDS (minimum data set) with CAAS (care area assessment summary) for Resident # 95 was the admission assessment dated 12/27/17. This MDS assessed the resident with a cognitive score of 14, indicating the resident was intact for daily decision making skills. The resident was not triggered for return to community in the CAAS section.

The resident's discharge MDS RNA (return not anticipated) was reviewed dated 01/03/18 documented that the resident was discharged on 01/03/18. The MDS additionally documented the discharge as unplanned, and that the resident went to an acute care hospital.

During clinical record review on 02/22/18 11:17 a.m., the clinical record revealed in the nursing notes that the resident was discharged home. Further review of the clinical record revealed that Resident # 95 was a PACE Medicaid resident and was documented throughout the nursing notes that the resident was planning to return home.

SW (social worker) notes were not found

F 656

b. An audit of all quarterly MDS for the last 30 days completed on 3/14/2018 by MDS personnel to ensure care plans were developed concerning positioning related to impaired range of motion to the lower extremities.
c. An audit of all residents with physician orders for a BiPAP machine was conducted on 3/13/2018 by MDS personnel to ensure development of a care plan.
d. An audit of all residents with orders for a central line was completed on 3/12/2018 by MDS personnel to ensure development of a comprehensive care plan for care of a central line.
3.
a. Social Services Director was educated by facility Executive Director on 3/14/2018 regarding need for CCP of discharge/return to the community. A weekly audit of new admissions to be conducted by facility Social Services Director to ensure development of a CCP for discharge/return to the community.
b. MDS personnel in-serviced on 3/14/2018 by Regional MDS Specialist regarding development of care plans related to impaired range of motion. A weekly audit of quarterly MDS□s to be completed by MDS personnel for a period of 30 days to ensure development of care plans related to impaired range of motion.
c. MDS personnel in-serviced on 3/14/2018 by Regional MDS Specialist regarding development of a care plan related to use of a BiPAP machine. New physician orders to be audited by MDS personnel three times per week by MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 656 Continued From page 29
regarding Resident # 95.

The resident's CCP (comprehensive care plan) was then reviewed and did not address the resident's discharge plan. Physician's progress notes from the facility did not document the residents discharge in any way. There was no information indicating this was a planned discharge, other than nursing notes documenting that the resident planned and wanted to return home soon.

The administrator and DON (director of nursing) were made aware of the above information in a meeting with the survey team on 02/22/18 at the end of the day. The administrator stated that the resident was a PACE patient and that the resident was only here (at facility) for respite care. The administrator stated the resident went home on 01/03/18. The administrator and DON were made aware that the resident's clinical record did not address any of that information.

On 02/23/18 at approximately 7:31 a.m., the MDSC (minimum data set coordinator) was interviewed regarding Resident # 95 and was asked where the information for Resident # 95 came from (discharge unplanned and discharge to hospital). The MDSC stated that she didn't know where she got the information. The MDSC was then asked to look up to see if she could find any information on this resident. The MDSC then stated that this information was coded in error, the resident did not go to the hospital and it was a planned discharge and that she would make a correction. The MDSC was then asked about the resident's CCP for discharge. The MDSC stated that the SW updates the care plans for discharge and that the former SW had left and the new SW

F 656

personnel for a period of 30 days to ensure use of BiPAP machines are care planned.
d. MDS personnel in-serviced on 3/14/2018 by Regional MDS Specialist regarding development of CCP for the care of a central line. New physician orders to be audited three times per week by MDS Personnel for a period of 30 days to ensure the development of a CCP related to the care of a central line.
4. The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 656 — F 656

Continued From page 30
had came to the facility on 01/22/18, after the resident had been discharged.

No further information and/or documentation was provided prior to the exit conference on 02/23/18 at 12:45 p.m.

2. Resident #83 had no plan of care developed concerning positioning related to impaired range of motion of her lower extremities.

Resident #83 was admitted to the facility on 9/1/06 with diagnoses that included high blood pressure, dementia, depression, joint derangement, anemia and cataracts. The minimum data set (MDS) dated 2/7/18 assessed Resident #83 with severely impaired cognitive skills and impaired functional range of motion in both her lower extremities.

Resident #83 was observed on 2/20/18 at 11:01 a.m. seated in a wheelchair without any support for her feet or lower legs. There were no leg/footrests on the resident's wheelchair. The resident's feet pointed downward and with her heels approximately 4 to 5 inches above the floor and her toes approximately 1 to 2 inches above the floor.

Resident #83's plan of care (revised 12/5/17) listed no problems, goals and/or interventions regarding impaired range of motion or positioning of her feet/lower legs.

On 2/22/18 at 9:15 a.m., the certified nurses' aide (CNA #1) caring for Resident #83 was interviewed about the resident's feet hanging without footrests. CNA #1 stated the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	**2081 LANGHORNE ROAD LYNCHBURG, VA 24501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 31	F 656		

used to have footrests but they were discontinued "awhile back." When asked if the resident had any other interventions to support her feet, CNA #1 stated she did not know and therapy took care of positioning.

On 2/22/18 at 9:39 a.m., the therapy director was interviewed about Resident #83's wheelchair positioning without feet support. The therapy director stated she was not aware of any positioning concerns for Resident #83.

On 2/22/18 at 10:21 a.m., the licensed practical nurse (LPN #3) caring for Resident #83 was interviewed about the resident seated without feet supports. LPN #3 stated the resident's feet/toes had been pointed downward for a long time. LPN #3 stated the resident was up in the wheelchair occasionally for activities but mostly stayed in bed. LPN #3 stated there was nothing in the care plan about positioning/support for the resident's feet when up in the wheelchair. LPN #3 stated the resident at one time had therapeutic boots but did not like them so they were discontinued.

On 2/22/18 at 10:32 a.m., the registered nurse (RN #2) responsible for Resident #83's care plan was interviewed about positioning for the resident's feet. RN #2 reviewed the care plan and stated she did not see any interventions on the care plan specifically about positioning and the resident's impaired range of motion. RN #2 stated, "The only thing I see is the pressure relief mattress."

These findings were reviewed with the administrator and director of nursing during a meeting on 2/22/18 at 5:25 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 32	F 656		

3. Resident # 39 did not have a care plan to address the care and use of a BiPAP (Bi-level Positive Airway Pressure) machine.

R 39 was admitted to the facility 9/19/17 with diagnoses to include, but not limited to: chronic respiratory failure, COPD, bronchiectasis (chronic dilation of the bronchi), anxiety, depression, and epilepsy.

The most recent MDS (minimum data set) was a quarterly review dated 12/14/17 and had R 39 coded as cognitively intact with a total summary score of 15 out of 15.

On 2/20/18 during a resident interview beginning at 3:18 p.m. R 39 commented to this surveyor "My BiPAP machine here has been broken for about two weeks; the people here have looked at it, and I think the nurses have tried to call the company but I guess they're having a hard time getting in touch with them; you know how that goes! I hope I get it fixed pretty soon, though; since I haven't been able to use it I'm not sleeping very well and I sleep later than I want to because of that."

On 2/21/18 at approximately 2:00 p.m. during review of the clinical record, it was noted the February 2018 POS (physician order summary) did not include orders for R 39's BiPAP machine. Further review of the CCP failed to reveal interventions to address the use of the BiPAP machine.

On 2/21/18 at 3:40 p.m. The DON (director of nursing) and the regional nurse consultant were interviewed about R 39's BiPAP machine. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 33	F 656		

DON stated "It's not broken. The current machine in use just doesn't have a pressure setting high enough for her due to her disease; for that reason, she thinks it's broken. We have been in touch with the company and we are getting her a new one which should be here soon. She does refuse to wear it at times. There was a consult dated 12/28/17 about resuming her BiPAP use, but it looks like the orders were signed off by nursing but not transcribed to the 'batch' orders to be on the POS. It should also be on the care plan." The DON further stated that MDS staff developed that area of the care plan.

On 2/22/18 during a meeting with facility staff beginning at 7:44 a.m. the administrator and DON were informed of the above findings. During the meeting the DON gave this surveyor a copy of the updated care plan to include the BiPAP machine, and a copy of physician orders for the BiPAP machine use, including the settings and care of the machine.

On 2/22/18 at 3:15 p.m. RN (registered nurse) # 2 was asked about the care plan for the BiPAP machine. RN # 2 stated "Prior to yesterday there were no 'batch' orders for the machine, so it wasn't care planned."

No further information was provided prior to the exit conference.

4. Facility staff failed to formulate a comprehensive care plan for the care and maintenance of a central line.

Resident #43 was originally admitted to the facility on 01/31/18 and readmitted on 02/08/18 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 34 diagnoses including, but not limited to: Endocarditis, Infection caused by an implantable cardiac device, Protein/Calorie Malnutrition, Dementia, Depression, Anxiety and Stage 4 Pressure Ulcer. The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 02/15/18. Resident #43 was assessed as moderately impaired in his cognitive status with a total cognitive score of 10 out of 15. Resident #43 was interviewed on 02/21/18 at 10:45 a.m. Resident #43 stated he was receiving antibiotics via a central line IV (intravenous) catheter three times a day. The resident proceeded to show this surveyor the central line located in his right chest wall. Resident #43's clinical record was reviewed on 02/20/18 at approximately 2:00 p.m. During this review the following physician orders were noted, "...Cefazolin Sodium Solution Reconstituted 1 GM [gram] Use 2 gram intravenously every 8 hours for infection...Order Date/Start Date 02/21/2018...Normal Saline Flush Solution (Sodium Chloride Flush) Use 3 cc [cubic centimeters] intravenously before and after iv meds for iv abts [antibiotics] before and after iv meds..." There was no physician orders for the care and maintenance of the central venous catheter other than the prescribed medication orders. Subsequent review of the comprehensive care plan did not include any focus areas or interventions pertaining to the care and maintenance of a central venous catheter or for the administration of IV antibiotics and saline	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 656	Continued From page 35 flushes. The DON (director of nursing) was interviewed on 02/22/18 at approximately 2:10 p.m. regarding Resident #43's care plan for his central line and IV antibiotics. The DON stated, "MDS does the care plans. They run MD orders everyday and update the care plans. On the weekends, they run orders on Monday mornings and update." This surveyor and the DON reviewed Resident #43's care plan. The DON stated, "That sounds like a peripheral IV care plan," then shook her head. The Administrator was apprised of the above findings during a meeting with the survey team on 02/22/18 at approximately 5:25 p.m. No further information was received by the survey team prior to the exit conference on 02/23/28.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		4/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 657	Continued From page 36 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to review and revise a comprehensive care plan for one of 32 residents, Residents #71. 1. Resident #71 (R 71) care plan was not revised to indicate the treatment or the knowledge of open wounds. Findings include: 1. R 71 was admitted to the facility originally on 08/15/17. Diagnoses for R 71 included, but were not limited to: DM (diabetes mellitus) with foot ulcers, neuropathy, morbid obesity. The most current MDS (minimum data set) was a quarterly assessment dated 01/25/18. R 71 was assessed with a cognitive score of 14, indicating cognitively intact. On 02/20/18 11:41 AM an interview was conducted with R 71. During the interview, R 71 verbalized she has a pressure ulcer on buttocks and it was painful and the staff was putting	F 657	1. Resident #71's care plan has been revised to indicate the treatment and knowledge of open wounds. 2. A 100% skin audit was conducted on 3/9/2018 by facility DON and designee to observe for open wounds and care plans adjusted accordingly where necessary. 3. Facility MDS personnel and DON in-serviced on 3/14/2018 by Regional MDS Specialist regarding the knowledge of, and care planning of, the treatment of open wounds. An audit of order listing report by facility DON and MDS personnel five times a week for a period of 30 days to ensure treatments are care planned. 4. The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	**2081 LANGHORNE ROAD LYNCHBURG, VA 24501**

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F 657	Continued From page 37 Greer's goo on her bottom. Review on R 71's record (including progress notes, and weekly skin assessments) did not evidence pressure or wound problems to R 71's buttocks. R 71's care plan was also reviewed and indicated that R 71 was admitted with pressure ulcers to the buttocks on 8/15/17 and the pressure ulcers were resolved on 9/12/17. The care plan did not evidence that there were current pressure ulcers to the buttocks. On 02/22/18 at 11.10 AM this surveyor asked the wound nurse (registered nurse, RN 1) to assess residents buttocks. This surveyor and RN #1 observed R 71's buttocks. R 71 had 2 open wounds, one on each side of R 71's buttocks approximately the size of a dime. RN #1 verbalized that he should have been notified of the 2 wound areas so that he could contact wound care services for treatment. RN #1 verbalized that resident was not put on his list to evaluate or treat and this was the first time he knew about the concern. RN verbalized that the wounds looked to be at a stage 2 ulcer. The above information was presented to the Director of nursing (DON) on 2/22/18 at 1:54 PM . The DON verbalized that treatment should have been in place and the wound nurse should have been notified and the care plan updated to reflect open wounds to the buttocks. 02/22/18 05:30 PM The above information was presented to the DON and administrator during an end of day meeting. No other information was presented prior to exit	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 657	Continued From page 38 conference on 2/23/18	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, complaint investigation and clinical record review, the facility staff failed to follow professional standards of care for two of 32 residents in the survey sample. 1. Resident #195's provider was not promptly notified of refused medications. Verbal reports to the nurse practitioner of the medication refusals were not documented in the clinical record. 2. Facility staff failed to obtain physician orders for care and maintenance of a central venous catheter for Resident #43. The findings include: 1. Resident #195's provider was not promptly notified of a refused medication. Verbal reports to the nurse practitioner of the medication refusals were not documented in the clinical record.	F 684	1. a. Resident #195 is no longer a resident in our facility. b. Resident #43 no longer has a central line. 2. a. An audit of all residents with current orders for Lovenox in the past 30 days, was completed on 3/13/2018 by facility DON and designee to ensure physician notification occurred. No further issues identified. b. An audit of all residents with a central line was completed on 3/12/2018 by DON to ensure physician orders for care were timely obtained. No further issues identified. 3. Inservice training of Licensed Nursing Staff was initiated on 3/8/2018 by facility DON or designee regarding physician notification for refusal of Lovenox as well as obtaining physician orders for the care of a central line. Facility DON or designee	4/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 684

Continued From page 39

Resident #195 was admitted to the facility on 6/2/17, was a re-admitted on 9/15/17 and died in the facility on 11/4/17. Diagnoses for Resident #195 included lung cancer, bladder cancer, heart failure, high blood pressure, peripheral vascular disease, chronic deep vein thrombosis and COPD (chronic obstructive pulmonary disease). The minimum data set (MDS) dated 10/8/17 assessed Resident #195 as cognitively intact.

Resident #195's closed clinical record documented a physician's order dated 9/15/17 for the medication Enoxaparin Sodium (Lovenox) 120 mg (milligrams)/0.8 mL (milliliters) 1 syringe two times per day for prevention of deep vein thrombosis.

Resident #195's medication administration record (MAR) documented refusal of 20 doses of Lovenox on the following dates in October 2017. The dates of refusal were documented as follows: 9/30/17, 10/2/17 through 10/5/17 and 10/7/17 through 10/9/17, 10/12/17, 10/13/17, 10/18/17, 10/23/17, 10/26/17, 10/27/17 and 10/30/17.

Nursing notes documented the resident refused the Lovenox injections as listed on the MAR and other prescribed medications. A nursing note dated 10/4/17 documented, "Patient alert and verbal...Patient requires encouragement to take all prescribed meds [medications], patient refused lovenox injection..." A nursing note dated 10/8/17 stated, "Resident alert and oriented...Resident refused all morning medications, stating 'I don't want a shot or anything else, all I want is my lyrica and my antibiotics, nothing else..."

The clinical record documented no notification to the physician and/or nurse practitioner (NP)

F 684

to complete an audit three times a week for 30 days of all residents with physician orders for Lovenox to ensure physician notification of refusals are documented. Facility DON or designee to complete an audit three times a week for 30 days of all residents with central lines to ensure physician orders for care have been obtained.

4. The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING _______ B. WING _______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	**2081 LANGHORNE ROAD LYNCHBURG, VA 24501**

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F 684	Continued From page 40	F 684		

regarding the refusals until 10/11/17. A progress note by the NP dated 10/11/17 documented, "Patient was seen on 10/10/17. Spoke with patient today because he is refusing medications. He said he doesn't want to take anything but his Lyrica and antibiotics. He is also refusing Lovenox injections that is treating DVT [deep vein thrombosis] because they hurt..." (sic)

On 2/22/18 at 1:45 p.m., the director of nursing (DON) was interviewed about Resident #195 and notification to the physician and/or NP about medication refusals. The DON stated the resident refused most medications starting the first of October 2017. The DON stated nurses were supposed to document in notes any notifications to the physician or NP. The DON stated the NP was notified verbally on multiple occasions about the resident's refusal of medicines. The DON stated she did not think the nurses documented the notifications "because he refused so much." The DON stated the NP was "completely aware" of the resident's medication refusals.

On 2/22/18 at 2:12 p.m., a licensed practical nurse (LPN #3) that cared for Resident #195 during his stay was interviewed. LPN #3 stated the NP was in the facility four days each week. LPN #3 stated she knew she told the NP about Resident #195's refusals. LPN #3 stated she did not remember when she notified the NP. LPN #3 stated notifications were supposed to be entered into nursing notes.

On 2/23/18 at 7:20 a.m., the DON was interviewed again about any further information about when the NP or physician was notified concerning Resident #195's medication refusals

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 41	F 684		

that started in October 2017. The DON stated she did not find any documentation about the notification. The DON stated nurses were expected to notify the provider concerning medication refusal "the same day" they occurred. The DON stated notification to the provider was supposed to be documented in nursing notes. The DON stated she talked with the NP and he stated he was notified verbally about Resident #195's refusals. The DON did not have any evidence of when the notifications took place.

On 2/23/18 at 8:50 a.m., the NP caring for Resident #195 was interviewed. The NP stated he was not notified of Resident#195's refusals until 10/11/17. The NP stated the nurses kept a "rounding sheet" each week listing residents that needed to be seen. The NP stated Resident #195 was not on this list prior to 10/10/17. The NP stated he was not aware the resident was refusing Lovenox and other medicines until 10/11/17.

The facility's policy titled Resident Change of Condition Physician Notification (undated) stated, "The attending physician or physician on call will be notified with changes in a resident's condition or health status...Seven (7) days a week, attending physicians or physician on call is to be notified of all condition or health status changes...The nurse should...document time of call, physician or nurse practitioner or other person spoken to, reason for call and results or orders received..."

The Lippincott Manual of Nursing Practice 10th edition on page 16 states concerning standards of care, "A deviation from the protocol should be documented in the patient's chart with clear,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684		F 684		

Continued From page 42

concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events." This reference states on page 16 concerning common departures from standards of care, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record, administer medications as ordered..." Page 17 of this reference includes in a lists as departures from standards of care, "Failure to communicate or document a significant change in a patient's condition to appropriate professional... Failure to administer medications properly and in a timely fashion or to report and administer omitted doses appropriately..." (1)

The Nursing 2017 Drug Handbook on page 526 describes Lovenox as an anticoagulant used for the treatment and prevention of pulmonary embolism and deep vein thrombosis. (2)

These findings were reviewed with the administrator on 2/23/18 at 9:12 a.m.

This was a complaint deficiency.

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	**2081 LANGHORNE ROAD LYNCHBURG, VA 24501**

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F 684 Continued From page 43 F 684

(2) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.

2. Facility staff failed to obtain physician orders for the care and maintenance of a central line to include dressing changes, and cap changes.

Findings included:

Resident #43 was originally admitted to the facility on 01/31/18 and readmitted on 02/08/18 with diagnoses including, but not limited to: Endocarditis, Infection caused by an implantable cardiac device, Protein/Calorie Malnutrition, Dementia, Depression, Anxiety and Stage 4 Pressure Ulcer.

The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 02/15/18. Resident #43 was assessed as moderately impaired in his cognitive status with a total cognitive score of 10 out of 15.

Resident #43 was interviewed on 02/21/18 at 10:45 a.m. Resident #43 stated he was receiving antibiotics via a central line IV (intravenous) catheter three times a day. The resident proceeded to show this surveyor the central line located in his right chest wall.

Resident #43's clinical record was reviewed on 02/20/18 at approximately 2:00 p.m. During this review the following physician orders were noted, "...Cefazolin Sodium Solution Reconstituted 1 GM [gram] Use 2 gram intravenously every 8 hours for infection...Order Date/Start Date 02/21/2018...Normal Saline Flush Solution

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	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 44	F 684		

(Sodium Chloride Flush) Use 3 cc [cubic centimeters] intravenously before and after iv meds for iv abts [antibiotics] before and after iv meds..." There was no physician orders for the care and maintenance of the central venous catheter other than the prescribed medication orders.

During an end of the day meeting on 02/21/18, with the Administrator and DON (director of nursing) this surveyor requested a policy referring to the care and maintenance of a central venous catheter. This surveyor received a total of three policies concerning care of a central venous catheter in the early a.m. of 02/22/18.

At approximately 1:10 p.m. the DON stated that the facility policy named "Central Venous Catheter Dressing Changes should be followed first and if this isn't the correct policy, use the [IV company] policy." Included in this policy was, Purpose: The purpose of this procedure is to prevent catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings...General Guidelines: ...5. Change transparent semi-permeable membrane (TSM) dressings at least every 7 days and PRN [as needed] (when wet, soiled, or not intact). 6. Change needleless access device, extension tubing, and stabilization device at time of routine dressing change..." The DON stated, "Yes, I consider needleless access device as the caps." The DON also stated regarding lack of physician orders for care and maintenance of his central line, "There should be." The DON was questioned if Resident #43's dressing and caps had ever been changed since his admission because there was no documentation in the clinical record to support this had been done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ____ B. WING ____	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 684	Continued From page 45 The DON stated, "I know the dressing and caps were changed because I did it myself, but I also know if it isn't documented it wasn't done." The Administrator was apprised of the above findings during a meeting with the survey team on 02/22/18 at approximately 5:25 p.m. No further information was received by the survey team prior to the exit conference on 02/23/28.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview the facility staff failed to assess and provide treatment for an open wound for one of 32 residents: Resident # 71. The facility failed to assess and provide necessary treatment to open wounds for Resident #71 (R 71). Findings include:	F 686	1. Resident #71 has been assessed and orders for treatments to open wounds obtained. 2. A 100% audit of skin assessments was conducted on 3/9/2018 by DON and designees and orders obtained for any identified open wounds. 3. Inservice training of Licensed Nursing Staff was initiated on 3/8/2018 by facility DON regarding assessing and obtaining	4/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 686 Continued From page 46

R 71 was admitted to the facility originally on 08/15/17. Diagnoses for R 71 included, but were not limited to: DM (diabetes mellitus) with foot ulcers, neuropathy, morbid obesity.

The most current MDS (minimum data set) was a quarterly assessment dated 01/25/18. R 71 was assessed with a cognitive score of 14, indicating cognitively intact.

On 02/20/18 11:41 AM an interview was conducted with R 71. During the interview, R 71 verbalized says she has a pressure ulcer on buttocks and it was painful and the staff was putting Greer's goo on her bottom.

Review on R 71's record (including progress notes, and weekly skin assessments) did not evidence pressure or wound problems to R 71's buttocks. R 71's care plan was also reviewed and indicated that R 71 was admitted with pressure ulcers to the buttocks on 8/15/17 and the pressure ulcers were resolved on 9/12/17. The care plan did not evidence that there were current pressure ulcers to the buttocks.

On 02/22/18 at 11.10 AM this surveyor asked the wound nurse (registered nurse, RN 1) to assess residents buttocks. This surveyor and RN #1 observed R 71's buttocks. R 71 had 2 open wounds, one on each side of R 71's buttocks approximately the size of a dime.

RN #1 verbalized that he should have been notified of the 2 wound areas so that he could contact wound care services for treatment. RN #1 verbalized that resident was not put on his list to evaluate or treat and this was the first time he

F 686

necessary treatment orders for open wounds. An audit of weekly skin assessments to be completed three times a week for a period of 30 days to ensure open wounds are identified and treatment orders obtained.
4. The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 686	Continued From page 47 knew about the concern. RN verbalized that the wounds looked to be at a stage 2 ulcer but was not sure of the wound being arterial or venous based on the resident underlying conditions of diabetes, and cellulitis. The above information was presented to the Director of nursing (DON) on 2/22/18 at 1:54 PM . The DON presented skin assessment from the first week in January 2018 through present day. The skin assessments did not evidence any open areas to the buttocks. The DON verbalized that treatment should have been in place and the wound nurse should have been notified and the care plan updated to reflect open wounds to the buttocks. 02/22/18 05:30 PM The above information was presented to the DON and administrator during an end of day meeting. No other information was presented prior to exit conference on 2/23/18	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		4/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 688

Continued From page 48

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to ensure proper wheelchair positioning for one of 32 residents in the survey sample. Resident #83, with impaired range of motion in her ankles and feet, was positioned in her wheelchair without footrests or support for her feet and lower legs.

The findings include:

Resident #83 was admitted to the facility on 9/1/06 with diagnoses that included high blood pressure, dementia, depression, joint derangement, anemia and cataracts. The minimum data set (MDS) dated 2/7/18 assessed Resident #83 with severely impaired cognitive skills and impaired functional range of motion in both her lower extremities.

Resident #83 was observed on 2/20/18 at 11:01 a.m. seated in a wheelchair without any support for her feet or lower legs. There were no leg/footrests on the resident's wheelchair. The resident's feet pointed downward with her heels approximately 4 to 5 inches above the floor and toes 1 to 2 inches above the floor.

Resident #83's plan of care (revised 12/5/17) listed no problems, goals and/or interventions regarding impaired range of motion or positioning of her feet/lower legs. The clinical record

F 688

1. Resident #83 has been provided with proper wheelchair positioning.
2. Therapy personnel to screen residents to ensure proper wheelchair positioning to support feet and lower legs. All identified issues to be corrected.
3. Inservice training for Licensed and Certified nursing staff initiated on 3/15/2018 by Director of Rehab or designee regarding proper wheelchair positioning. Facility DON or designee to complete a weekly audit of quarterly therapy screens for the next 30 days to ensure proper wheelchair positioning.
4. The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 49	F 688		

documented no physician orders regarding care/positioning for joints with impaired range of motion.

On 2/22/18 at 9:15 a.m., the certified nurses' aide (CNA #1) caring for Resident #83 was interviewed about the resident's feet hanging without footrests while in the wheelchair. CNA #1 stated the resident used to have footrests but they were discontinued "awhile back." When asked if the resident had any other interventions to support her feet, CNA #1 stated she did not know and therapy took care of positioning.

On 2/22/18 at 9:39 a.m., the therapy director was interviewed about Resident #83's wheelchair positioning without feet support. The therapy director stated she was not aware of any positioning concerns for Resident #83.

On 2/22/18 at 10:21 a.m., the licensed practical nurse (LPN #3) caring for Resident #83 was interviewed about the resident seated without feet support. LPN #3 stated the resident's feet/toes had pointed downward for a long time. LPN #3 stated the resident was up in the wheelchair occasionally for activities but mostly stayed in bed. LPN #3 stated there was nothing in the care plan about positioning/support for the resident's feet when up in the wheelchair. LPN #3 stated the resident at one time had therapeutic boots but did not like them so they were discontinued.

On 2/22/18 at 1:34 p.m., the therapy director was interviewed again about Resident #83's observed wheelchair positioning without footrests. The therapy director stated the resident needed footrests and possibly a cushion to keep her more upright in the wheelchair when seated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 688	Continued From page 50 These findings were reviewed with the administrator and director of nursing during a meeting on 2/22/18 at 5:25 p.m.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, facility document review, and during a complaint investigation, the facility staff failed to ensure an environment free of accident hazards and failed to ensure adequate supervision to prevent accidents for three of 32 residents (Residents # 64, # 38, and # 88); failed to ensure adequate supervision for one of 32 resident (Resident # 145), which resulted in harm and failed to ensure for one of 32 residents that sunscreen was applied to the top of the foot area for the prevention of sunburn resulting in a blistering sunburn which had to be surgically debrided (procedure requiring local anesthetic and removal of dead skin tissue with a scalpel) resulting in harm for Resident # 347. 1. The facility staff failed to ensure safety and supervision for Resident # 145 for access to the smoking area, as a result the resident fell in koi pond and was found by another resident;	F 689	a. Resident was removed from outside area, wet clothes removed, and dried, and sent to local hospital for evaluation. courtyard was blocked off immediately to limit access by other patients. b. Resident #347 is no longer a resident of our facility. c. Resident #64□s Vape device is now properly secured at receptionist desk or designated area. d. Pull cord in restroom of resident #38 has been replaced. e. Pull cord for resident #88 has been replaced. 2. a. All residents who go outside unattended are at risk. b. All residents who go outside in the sun are at risk for sunburn. c. An audit of all residents who smoke was conducted by facility DON on	4/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 689 Continued From page 51

Resident # 145 was sent to the hospital and treated for hypothermia, partial seizures, and Influenza B (FLU). The resident returned to the facility 8 days later. This resulted in harm.

2. Resident # 347 sustained a blistering sunburn to the tops of both feet which had to be surgically debrided weekly in excess of 88 days resulting in harm.

3. The facility failed to ensure Resident # 64's Vape device and vaping liquids were properly stored at the Nurse's Station, and in accordance with the plan of care, when not in use.

4. Residents #38 had no pull cord on the emergency call light in the resident's restroom.

5. Residents #88 had no pull cord on the emergency call light in the resident's restroom.

Findings include:

1. The facility staff failed to provide adequate supervision to Resident # 145 for access to the smoking area, which resulted in the resident falling into a koi pond. The resident was found by another resident and was sent to the hospital for treatment. This resulted in harm.

Resident # 145 was admitted to the facility on 01/31/18. Diagnoses for Resident # 145 included, but were not limited to: Paranoid schizophrenia, anxiety disorder, depression, Vitamin D deficiency, symbolic dysfunction, bipolar disorder, and weakness. The resident discharged out of the facility on 02/07/18, following a fall into the koi pond in the smoking

F 689

3/9/2018. It was determined that no other residents utilize Vape devices.
d. A facility wide audit was conducted on 3/13/2018 by maintenance personnel to ensure pull cords were in place. No other issues identified.
3. Maintenance personnel have installed new LED lighting around koi pond, installed temporary fencing around pond with permanent fencing to be installed once delivered, locks were installed on door to be locked during dark hours, and upgraded flood lighting installed. Maintenance personnel to inspect pond area weekly to ensure interventions are in working order. Inservice training of facility staff by DON and designee regarding the monitoring of residents who are designated as supervised smokers initiated 3/8/2018. Facility staff in-service training initiated on 3/8/2018by DON and designees regarding communicating work orders to maintenance staff regarding maintenance needs of residents including, but not limited to, the installation of pull cords in restrooms, etc.. All residents identified as smokers were in-serviced on 3/6/2018 by facility DON and Social Services Director regarding smoking policy and ensuring that Vape and other smoking materials are locked up in accordance with facility policy. Facility activities staff were in-serviced on 3/9/2018 by facility DON or designee regarding availability and utilization of sunblock during organized outside activities. A audit of facility smoking area containing koi pond to be completed by facility maintenance personnel five times

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 689 Continued From page 52

area and was readmitted to the facility on 02/15/18.

The most current MDS (minimum data set) was a discharge return anticipated/14 day admission (completed on 02/13/18), the ARD (assessment reference date) was 02/08/18. Section C (Cognitive Patterns) of this MDS was blank. There was no cognitive information documented on this resident.

This MDS assessed the resident as requiring supervision with one person physical assist for bed mobility/transfers and as requiring supervision with ambulation (no physical help), the resident was additionally assessed for locomotion on/off the unit as 7/0 (indicating that this activity only happened once or twice without support from staff), the resident was assessed for extensive assistance from staff for dressing, toileting and hygiene with one person physical assist.

This MDS assessed the resident as 'not steady, but able to stabilize without human assistance" for moving from a seated to standing position, walking, turning around, and surface to surface transfer. The resident was coded on this MDS as a current smoker and using a w/c for ambulation/mode of transportation.

A complaint investigation was conducted on 02/20/18 through 02/23/18. An allegation within the complaint alleged that the resident fell into the koi pond, was unable to get out and was found by another resident and subsequently went to the hospital for treatment.

On 02/20/18 at approximately 10:30 a.m., a brief

F 689

a week for a period of 30 days to ensure that fencing and other safety measures put in place as part of POC dated 2/15/2018 are in working order. A weekly audit of facility organized outdoor activities to be completed by Activities Director for a period of 90 days to ensure availability and implementation of sunblock. An audit of facility smoking box to be completed three times a week for a period of 30 days by facility DON or designee to ensure Vape devices and vaping liquids are properly stored. Facility maintenance personnel to audit facility resident restrooms on a weekly basis for a period of 60 days to ensure pull cords are installed and operational.

4. The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 689	Continued From page 53	F 689		

entrance conference was conducted with the administrator who was made aware of follow up from FRIs (facility reported incidents) and that there were complaints. The administrator stated that he would provide information and follow up for FRIs and information related to the incident concerning Resident # 145. The administrator provided a list of smokers (supervised and unsupervised) and an 'updated' (as of 2/20/18) supervised smoking assignment document.

Resident # 145 was observed multiple times during the survey process in his room in bed and in the hall area in his w/c (wheel chair), the resident was observed as slow for mobility and response when spoken to.

On 02/22/18 at 8:40 a.m., the smoking area was observed, no residents were in the area at this time. The door leading to the outside courtyard was not locked and when opened, no alarms of any type were seen or heard to evidence notification to staff that the outside area had been accessed.

On 02/22/18 at 9:40 a.m., the resident was observed in his w/c in the smoking with staff.

Resident # 145's clinical record was reviewed. A smoking assessment dated 02/01/18 (timed 10:14) documented that the resident was able to call for help if a lit cigarette ash or cigarette falls on the person and was receiving medications with the potential to cause sedation, did participate in the education and care planning regarding smoking activities and was documented to smoke independently. The assessment additionally documented that the resident may smoke unsupervised in designated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	**2081 LANGHORNE ROAD LYNCHBURG, VA 24501**

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F 689	Continued From page 54	F 689		

areas.

An admission nursing assessment dated 02/01/18 documented, that the resident had slow comprehension and was oriented to person and was a current smoker and that the resident was oriented to the smoking rules. This assessment was signed completed on 02/08/18, the day after the resident's fall.

The resident's Kardex dated (01/31/18) was reviewed and documented that the resident is 'dependent' upon staff for smoking.

A fall risk assessment completed on 02/01/18 documented that the resident was a high risk for falls and had mild/moderate impairment in cognitive skills. This assessment also documented that the resident used a leg brace, w/c, walker and cane and that the resident wears glasses, but did not have them with him.

An elopement assessment dated 02/01/18 gave the resident a score of 12 (total score of 10 or greater, the resident should be considered at risk).

Resident # 145's physician's orders were reviewed, the resident did not have a physician's order to smoke, either assisted or unassisted.

Progress notes were then reviewed and documented the following:

02/01/18 [12:49 a.m.] - '...seemed to enjoy being at this facility...especially since he is able to smoke outside...'

02/01/18 [3:44 a.m.] - '...Resident ambulates with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 689	Continued From page 55	F 689		

cane...no behaviors...'

02/01/18 [10:24 a.m.] - "...Initial admission data collection review...SW [social worker]...Resident was laying on top of the bed, fully dressed with hood of coat on his head with his feet and legs hanging down and drooling...full code...resident is single...his half brother...and sister...visit if "I'm not drinking"...comments on education...states he has a doctorate from [name of a university] and worked at [name of company] 'I was a supervisor' Resident stated he is an Admiral [military history]...Medical and Psychiatric History: 'I have a clean track record and I am accountable'...Resident stated he does well with change and likes being at this new place "as long as he gets his cigarettes on time"...During the resident interview he expressed, "I want to retire and monitor at your residence"...."

02/02/18 [4:18 p.m.] - 'SW [social worker]...met face to face with resident...alert yet presents with confusion and appears to need psychiatric evaluation based upon his responses which indicate need. Resident is a smoker and states everything will be fine as long as he gets his cigarettes on time...will monitor follow progress.'

02/04/18 [2:37 p.m.] - "Behavior: PATIENT SEEN SMOKING IN HALLWAY BY STAFF, AND X 5 [five] CIGARETTE BUTTS FOUND UNDERNEATH HIS BED, AND X 2 [two] IN THE CLOSET...patient redirected cigarette put out, nurse along with other staff members stressed the importance of not smoking in the facility or bring [sic] cigarette butts from outside, patient has a lighter and will not allow it to be locked away...patient will be monitored Q [every] hour X [times] 24 HRS."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 689	Continued From page 56	F 689		

The resident's MARs (medication administration record) were reviewed and revealed a behavior observation sheet that documented the resident was exhibiting 'wandering/pacing' type behaviors on the evening shift on 02/04/18.

02/05/18 [1:26 p.m.] A note by the SW documented, '...referred to psychiatrist due to responses on initial admissions assessment.' No physician's orders were found for a psych consult and/or any documentation that the physician was made aware of any of the above information.

02/05/18 [5:19 p.m.] [Physician's Progress Note] documented by the NP [nurse practitioner] - '...paranoid schizophrenia...There are no notes that I could find about why patient is at [name of facility]...tobacco abuse...outside smoking used cigarettes [sic]...slow cognition...slow speech...oriented to self only...Plan: ...Resident requires nursing facility services for safety...' None of the information regarding the resident smoking in the hall, found with cigarettes in his room, making inappropriate responses (per the SW) were addressed by the NP.

02/07/28 [7:34 p.m.] '...found outside lying in pond, patient was lying on his back, his face was up...Patient non-compliant and has been going back and forth outside all day night and staff has redirected him X [times] 4 with effective results...difficulty talking and soak [sic] and wet from pond, dry clothing applied and wrapped with several blankets...send to ER [emergency room] for further evaluation...'

The resident was sent to the hospital on 02/07/18 between 7:15 p.m. and 7:30 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 689 Continued From page 57 F 689

According to the hospital H&P (history and physical) dated 02/08/18, the resident was admitted and treated at the hospital for, 'hypothermia, developed a fever during the night, found to have influenza [flu], and also now with concern of a partial complex seizures [sic]...apparently smokes a few cigarettes per day. He likes to be outside. He went outside apparently yesterday evening...ambulates with a cane as he has problems with the hip...suffered a fall and fell in the pond...apparently there...and could not get out, was there for, he says for about an hour or so...hypothermic...positive influenza B...he apparently became poorly responsive for a short time and there were twitching type moments of his right upper extremity...concerned, this could represent partial complex seizures..."

An addendum progress note from the hospital dated 02/08/18, documented that the patient was interviewed and examined and the resident stated he slipped into the pond and this was not an attempt to harm himself.

The resident's CCP (comprehensive care plan) was reviewed and documented, "...01/31/18...Unsafe Smoking: At risk for injury related to unsafe smoking...Will safely smoke at designated times, in designated areas with supervision of staff and have no smoking injuries or incidents...assist [name of resident] as needed to designated smoking area at designated times and supervise smoking...ensure [name of resident] does not leave designated smoking area with smoking materials...facility smoking policy will be reviewed with resident...will be instructed, and reminded as indicated that any smoking materials (cigarettes, cigars, pipes, matches,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	**2081 LANGHORNE ROAD LYNCHBURG, VA 24501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 58	F 689		

lighters) are to be turned into staff for management and dispensing...Smoking assessment to be completed on admission, quarterly and with any significant change in condition..."

Resident # 145 only had one smoking assessment completed (02/01/18); the resident did not have another smoking assessment completed upon readmission to the facility on 02/15/18.

An initial/interim care plan could not be located for Resident 145 for Falls. A fall risk assessment was completed on 02/01/18 and identified the resident as high risk for falls. The resident's CCP did not address falls and/or safety related to falls at all and was not developed until 02/08/18, after the resident had fallen in the pond in the smoking area.

The 'supervised smoking assignment' sheet presented by the administrator dated 12/11/17, with a hand written entry [update date] of 2/20/18 documented, "...Supervised smokers are allowed two cigarettes per 15 minute time period. Smokers must return all lighters, matches, etc. to the lockbox when finished smoking...New residents must be supervised until assessed for unsupervised privileges...all supervised smokers must be accompanied by a family member or an employee...smoking location for residents will be in the courtyard..."

The facility's "Smoking Protocol" was presented and documented, "While a resident at this facility, residents who wish to have smoking privileges may be allowed to do so subject to the following rules: "1. Prior to, or upon admission, resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING _____ B. WING _____	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 59 shall be informed about any limitations on smoking...2. Residents who smoke will have a smoking assessment done to determine independent or dependent smoking privileges...assessment will review cognitive ability, manual dexterity, and mobility...all residents that desire to exercise smoking...will be assessed to determine their smoking safety awareness...smoking assessments will be done as part of the admission process, quarterly, or when reassessment is indicated...the staff shall consult with the Attending physician and the IDT [interdisciplinary team] to determine any restrictions on a resident's smoking privileges...any smoking related privileges, restrictions and concerns shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues...facility may impose smoking restrictions on residents at any time if it is determined that the resident cannot smoke safely...The staff will review the status of a resident's smoking privileges periodically, and consult as needed with the Director of Nursing Services, IDT or attending physician...All smoking materials (cigarettes, cigars, e-cigarettes, etc.) will be kept at the nurses station or a facility designated area. Smoking materials will only be given to residents that have been determined to be safe/independent smokers during the designated smoke times...Residents determined to be "Supervised or Assisted Smokers" will receive their smoking material...by the staff member assigned to monitor the smoking area and those materials will be returned by that staff member to the...area for storage...Violations of this protocol or the smoking contract will bring restrictions of smoking privileges or possible discharge from the facility if behaviors present a danger to self or	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 60	F 689		

others. Actions such as smoking in non-designated areas, allowing any other resident to use, borrow, buy or have access to smoking material, or any other behavior considered to exhibit poor safety awareness may result in revocation of smoking privileges...Smoking restrictions shall be strictly enforced in all nonsmoking areas...Smoking shall be prohibited at all times in any room, storage area, or any other area where oxygen, flammable liquids, materials, or combustible gases are in use or stored...Smoking is prohibited in public areas or where groups of people frequently gather...The facility will have designated smoking areas. Designated smoking areas may be outside weather permitting...Staff members and volunteer workers shall not purchase and/or provide any smoking articles for residents unless approved by the charge nurse...The facility may check periodically to determine if residents have any smoking articles in violation of smoking policies...."

The administrator was interviewed on 02/22/18 at approximately 8:15 a.m. the administrator was asked for the investigation information for Resident # 145. The administrator presented a folder with information and statements regarding the incident. The investigation information was reviewed and the documentation included, but was not limited to the following:

A statement by LPN (Licensed Practical Nurse) # 30 documented in summary, that Resident # 145 was observed just prior to supper being argumentative with the nurse at the nurse's station at around 7:00 p.m. on 02/07/18 and that it wasn't long after that a page came over for all nurses and CNA's to go to the courtyard.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ____ B. WING ____	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689		F 689		

Continued From page 61

A statement by LPN # 12 documented that the resident was last seen around 6:00 p.m. the resident was seen ambulating using a walker around the facility and that the patient had been redirected four times prior to the incident, the resident kept going outside and continued to go back and forth outside in the rain and he would just sit at the table. At about 7:00 p.m., page overhead stated a patient is down in the courtyard.

A statement by OS (other staff) # 7 documented that at 7:10 p.m. on 02/07/18 a resident came to the receptionist desk and stated that someone had fallen into the pond in the courtyard, it was pitch black dark outside and she [OS # 7] couldn't see anything, [she] took a few steps and saw something floating in the pond, [she] ran back inside and paged for immediate assistance from nurses and CNA's to the courtyard, Resident # 145 was pulled from the pond after that.

A statement by a resident documented that it was dark and after dinner when the incident happened, this resident went outside via the courtyard door and kept hearing something, but didn't see anything because it was so dark, this resident made a loop around the pond to come in and that's when [this resident] saw someone in the pond on his back, [this resident] told him [Resident # 145] that he would go get help and went and told the person at the receptionist desk, everything got hectic and staff got him [Resident # 145] out of the pond and called 911.

On 02/22/18 at 9:59 a.m., LPN (Licensed Practical Nurse) # 44 was interviewed regarding Resident # 145 and was asked if the resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 62	F 689		

supposed to be supervised for smoking and/or going outside, the LPN stated, "Always."

An interview was attempted with Resident # 145 on several occasions, which the resident declined.

02/23/18 at 8:46 a.m., Resident # 19 was interviewed regarding Resident # 145 falling into the pond. Resident # 19 stated that it was around 7 or 8 at night when it happened. The resident was asked if this resident was supposed to be supervised in any way. Resident # 19 stated, "he was supposed to." Resident # 19 was asked if he was supervised, the resident stated, "No." Resident # 19 was asked how he knew that, Resident # 19 stated, "Everybody knows that." Resident # 19 stated that when you come here you need to be assessed and stated that Resident # 145 snuck out and fell in the pond. Resident # 19 stated that it rained all that day (when the fall happened) and he (Resident # 145) sat right there (pointing to spot) in the pouring rain.

This surveyor and Resident # 19 went to the courtyard area. The resident used the handicap accessible push button to open the door, the door opened giving access to the courtyard. No alarms/lighting or any type of notification and/or alerting system was seen or heard. It was cloudy, overcast with a light misting of rain and cool temperature. The table and chairs were wet, this surveyor wiped a chair off and sat down, the resident was in a w/c. Resident # 19 was asked if the door was locked to the outside the day the Resident # 145 fell, the resident stated, no-but they've been locking it at dusk now. Resident # 19 stated that he didn't like that because he has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING _______ B. WING _______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 689 Continued From page 63 F 689

insomnia and likes to go out to smoke when he can't sleep and was assessed to safely smoke alone, now he states that he can't do that because the guy fell in the fell in the pond. The resident stated, that he (Resident # 145) had been going in and out most of the evening, in and out of the rain.

On 02/23/18 at approximately 10:45 a.m., the complaint allegations for Resident # 145 were reviewed with the administrator and DON (director of nursing) in a meeting with the survey team. The administrator and DON were made aware of the serious concerns regarding Resident # 145's fall into the pond, the lack of safety awareness on the resident's part, as evidenced by smoking in the hall way, keeping cigarette butts in his room and closed with failure to return a lighter to staff, the facility staff failing to implement interventions for Resident # 145 for violating the smoking policy and failing to implement interventions and provide supervision for Resident # 145 related to falls.

The administrator stated in summary, 'Are you saying that a resident can't go out to the courtyard without being supervised even if they aren't smoking.' The administrator was made aware that is not what the survey team stated in any way. The administrator was again made aware that Resident # 145 was identified (by facility staff) as a risk in several care areas and that those identified concerns for this resident were not addressed or acted upon appropriately to ensure a safe environment and to prevent accidents for Resident #145, and all other residents.

No further information and/or documentation was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689		F 689		

Continued From page 64
presented prior to the exit conference on 02/23/18 at 12:45 p.m., to evidence that the facility staff provided a safe environment and appropriate supervision for Resident # 145 for the prevention of accidents, which resulted in harm.

This is a complaint deficiency.

2. Resident # 347 sustained a blistering sunburn to the tops of both feet which had to be surgically debrided weekly in excess of 88 days resulting in harm.

Resident # 347, a closed record review, was admitted to the facility 10/11/12 with a readmission date of 1/3/18. Resident # 347's diagnoses included, but were not limited to: acute kidney failure, chronic kidney disease/severe stage four, diabetes, and high blood pressure.

An MDS (minimum data set) quarterly review dated 6/7/17 had assessed the resident with moderate impairment in cognition with a total summary score of 12 out of 15.

The clinical record was reviewed 2/21/18 at 7:30 a.m. Nurses' notes were reviewed, and a note dated 5/18/17 documented "Resident complained of feet itching and asked nurse to check her feet. I observed open areas (1 on each upper foot). Wound nurse checked both and put treatment in place. Small blisters noted above areas. Resident had legs crossed and was rubbing them against each other. 98.2-72-156/76 (sic). MD notified. Called RP (responsible party) and (family member) with RP number not in service.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 65 (Family member's) mailbox full. Areas cleansed with normal saline, xeroform gauze applied with cover dressing. Dressing will be changed every other day. Resident advised not to rub feet/legs together but to let staff know when she is itchy." The note was signed by LPN (licensed practical nurse) # 2. The clinical record did not include any other nurses' notes about the areas to the tops of the residents feet. The next documentation located was an acute visit by the facility nurse practitioner (NP) dated 5/23/17 which documented ".....I was asked to see (name of resident) today by nursing due to 2 wounds on top of her feet.......she said they do hurt. She denies chest pain, shortness of breath....She does have wounds on both tops of her feet. It looks like it blistered up from whatever has happened and then has opened up. They do have Vaseline gauze on there at the time and they are covered. No drainage noted...... PLAN: I have asked the wound nurse and wound doctor to please see her today...." The "Wound Care Specialist Evaluation" forms were then reviewed. The first evaluation form, dated 5/23/17 documented "At the request of (name of physician), this 76 year old female was seen and evaluated today...." The evaluation form included documentation of surgical excisional debridement of the dorsal (top of foot) wounds of both feet. The treatment notes initially described the wound as an arterial wound; however, on the treatment evaluation form dated 6/20/17, an area marked "Additional information" documented "After investigation of events prior to my first exam it was noted by CNA caring for patient and the patient's nurse (name of LPN # 2) that day that this patient appeared to have	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 66	F 689		

sunburn on both feet dorsal surface. Wounds were red with blistering that day then note of necrosis the following day. Discussed case with wound care nurse, interim DON (director of nursing), and NP. All are in agreement that wounds are secondary to sun exposure."

The treatment notes, including weekly debridement, were reviewed to reveal the left foot healed 7/25/17, and the left foot healed 8/22/17. The wounds required treatment, including the weekly surgical debridement, in excess of 88 days.

Further review of the clinical record revealed skin assessment sheets, dated 5/3/17, 5/10/17, 5/17/17 were blank, with the exception of an assessment dated 5/31/17 prior to the resident going to the hospital for an unrelated event.

The assessment sheet(s) included "A. Skin Conditions. a. Skin Condition (list all areas NEW or OLD (sic)." Under this area were blocks where information was to be documented including site and description. Under "site" was documented "Other (specify)." Under "description" was documented "Tops of both feet. Dressings present. Treatment was in place before patient went to hospital." Under "b. New Areas Noted?" was marked "no." The rest of the assessment included "c. List the areas noted above which are new. d. Physician notified and Treatment Ordered for new areas? d.1. Name of Family Member Notified and Date. e. Referral made to wound care nurse for new areas?" All areas "b" through "e" had options of "Yes" or "No" to be marked, and the areas were not marked. Skin assessment sheets for June 2017 were also reviewed and were also blank with no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689		F 689		

Continued From page 67
assessments completed.

The care plan for May 2017 and June 2017 were reviewed, and a Focus area updated 5/22/17 documented "Bilateral open areas on top of both feet (3 degree burns). Under "Goals" was documented "(name of resident) will have no complications related to (SPECIFY skin injury type) (sic) of the (SPECIFY location) (sic) through the review date." The skin injury type and location was not documented. "Interventions" for the focus area included "Educate resident/family/caregivers causative factors and measures to prevent skin injury......... Follow facility protocols for the treatment of injury........Observe/document location, size and treatment of skin injury. Report abnormalities, nursing failure to heal, signs/symptoms of infection , maceration, etc. to MD........"

On 2/21/18 at 10:45 a.m. LPN # 2 was interviewed about the nursing note dated 5/18/17. LPN # 2 stated "I looked at her feet when she complained of them itching. We had a picnic here at the facility that day and we had put sunscreen on all the residents going outside to the picnic. We made sure faces, arms, etc. had sunscreen on them; I guess we didn't think about her feet. She had on slipper type shoes, and that was the pattern of the sunburn; the very tops of her feet had been exposed. We got her seen right away by the nurse practitioner and wound nurse; they started treatment."

On 2/21/18 at 4:00 p.m. an interview with the DON, who was identified as the interim DON when the incident occurred, and the regional nurse consultant was conducted. The DON and regional nurse consultant were asked about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689		F 689		

Continued From page 68

lack of nursing documentation, and lack of documentation on the skin assessment sheets. The regional nurse consultant stated "I believe the computer system was down that day, which is why there was no skin assessment sheets for that day. It would have been entered as a nursing note scanned into the system."

The regional consultant was then asked how long the system was down, as there were no skin assessments or nurses' notes regarding the wounds with the exception of 5/18/17, and a skin assessment form dated 5/31/17. The regional nurse consultant stated she was not sure how long the system was down, but thought it was down for about a day.

The DON was asked about the lack of documentation, and she stated "There should have been nursing notes. And we have identified the skin assessment forms as an area needing improvement; those should have been filled out as well." The DON further stated the facility had done a QAPI (quality assurance program improvement) since the incident to include orders for staff to apply sunscreen as needed for all residents going outside during the months a sunburn could be acquired. She also stated an education on skin assessment sheets was ongoing. The DON was also asked about the reference to a third degree burn on the care plan. She was asked if there was a definition of third degree burn, and if the resident had been diagnosed with a third degree burn.

On 2/22/18 at 7:44 a.m. the administrator and DON were informed of the above findings, and the possibility of a harm level citation. The administrator and DON had no comment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 69	F 689		

On 2/23/18 at 8:00 a.m. the DON informed this surveyor it was not clear why the sunburn was referred to as a third degree burn; there were no physician notes or diagnoses for a third degree burn.

No further information was provided prior to the exit conference.

THIS IS A COMPLAINT DEFICIENCY.

3. The facility failed to ensure Resident # 64's Vape device and vaping liquids were properly stored at the Nurse's Station, and in accordance with the plan of care, when not in use.

Resident # 64 in the survey sample, a 69 year-old male, was admitted to the facility on 2/3/17 with diagnoses that included chronic pain syndrome, anemia, depressive disorder, contracture of the left ankle, bacteremia, right below the knee amputation, anxiety disorder, and generalized muscle weakness. According to the most recent Annual Minimum Data Set, with an Assessment Reference Date of 1/27/18, the resident was assessed under Section C (Cognitive Patterns), as being cognitively intact, with a Summary Score of 15 out of 15.

During the orientation tour at 10:30 a.m. on 2/20/18, the resident was observed just inside the door of his room, seated in his wheelchair. While the surveyor engaged the resident in conversation, a Vape device was observed on the resident's night stand, located next to the door of the room. Asked if he vaped, Resident # 64 said, "Yes. I never smoked, but I do vape."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 70	F 689		

At 10:15 a.m. on 2/23/18, Resident # 64 was observed in the facility's Court Yard, seated in his wheelchair. At the time of the observation, the resident was engaged in vaping. When asked how much nicotine he used in his vape mixture, he said, "I use 3 milligrams." When he finished vaping, the resident placed the Vape device in his lap, wheeled himself out of the Court Yard, through the Day Room, and into the hallway where he joined other residents waiting to enter the Dining Room to play Bingo. When the Dining Room door was opened, Resident # 64 entered along with other residents to play Bingo.

At approximately 10:20 a.m. on 2/23/18, the surveyor went to the resident's room where two containers of vaping liquids were observed on a small table next to his night stand. The first container was labeled "KEEP IT 100 KRUNCHY SQUARES, 3 mg (milligrams) (0.3%), 100 ml (milliliters) (3.38 FL OZ) (fluid ounces)." The following warning also appeared on the label, "WARNING: This product contains nicotine. Nicotine is an addictive chemical."

The second container was labeled, "Gorilla Vapes." There was a space on the label for the flavor of the liquid, but the writing was smudged and unreadable. The label also included the following entry, "This product may contain nicotine, as addictive substance known to the State of California to cause birth defects or cancer."

At 10:25 a.m. on 2/23/18, LPN # 3 (Licensed Practical Nurse), the Charge Nurse on the unit where Resident # 64's room was located, was asked about the storage of his vaping supplies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING _______ B. WING _______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 71	F 689		

"He keeps them in his room," LPN # 3 said. "We (the nurses) have questioned why he is allowed to keep them in his room, but apparently someone gave him permission."

Review of Resident # 64's care plan, dated 1/23/18, revealed the following problem, "(Name of resident) has a Vape smoking device and is safe to use this unsupervised." The goal for the problem was, "(Name of resident) will be maintained in a safe environment, free from injury related to a Vape device through this review."

Interventions for the stated problem were:
"(Name of resident) will use his Vape device in designated smoking areas only.
Smoking assessment will be done on admission, quarterly, annual, sig (significant) change and PRN (as needed) to determine safety during smoking.
Smoking supplies will be kept in a locked box at the Nurse's Station. Supplies will be distributed by nursing staff."

4. The emergency call light in Resident #38's bathroom was missing a pull cord.

Resident #38 was admitted to the facility on 5/25/17 with a re-admission on 12/11/17. Diagnoses for Resident #38 included high blood pressure, diabetes, seizures, bipolar disorder, pneumonia and depression. The minimum data set (MDS) dated 12/21/17 assessed Resident #38 as cognitively intact.

2/22/18 at 11:15 a.m., Resident #38's bathroom was inspected. The emergency call light next to the toilet was missing a pull cord. The light had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ____ B. WING ____	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	**2081 LANGHORNE ROAD LYNCHBURG, VA 24501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689		F 689		

Continued From page 72
switch but no pull cord attached.

On 2/22/18 at 3:24 p.m., the licensed practical nurse (LPN #3) caring for Resident #38 was interviewed about the missing safety cord. LPN #3 stated she was not aware of the missing pull cord on the call light.

On 2/22/18 at 3:48 p.m., the maintenance director was interviewed about the missing pull cord on the call light. The maintenance director stated he was not aware of the missing pull cord. The maintenance director stated all staff members were supposed to monitor resident safety devices and write work orders for items needing repair.

These findings were reviewed with the administrator and director of nursing during a meeting on 2/22/18 at 5:25 p.m.

5. The emergency call light in Resident #88's bathroom was missing a pull cord.

Resident #88 was admitted to the facility on 5/28/13 with a re-admission on 5/31/14. Diagnoses for Resident #88 included heart failure, dementia, arthritis and deep vein thrombosis. The minimum data set (MDS) dated 2/9/18 assessed Resident #88 with severely impaired cognitive skills.

On 2/22/18 at 11:15 a.m., the bathroom in Resident #88's room was inspected. The emergency call light next to the toilet was missing a pull cord. The light had a switch but no pull cord attached.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 73 On 2/22/18 at 3:24 p.m., the licensed practical nurse (LPN #3) caring for Resident #38 was interviewed about the missing safety cord. LPN #3 stated she was not aware of the missing cord on the call light. On 2/22/18 at 3:48 p.m., the maintenance director was interviewed about the missing pull cord on the call light. The maintenance director stated he was not aware of the missing pull cord. The maintenance director stated all staff members were supposed to monitor resident safety devices and write work orders for items needing repair. These findings were reviewed with the administrator and director of nursing during a meeting on 2/22/18 at 5:25 p.m.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review the facility staff failed to transcribe orders for one of 32 residents in the survey sample: Resident # 39.	F 695	1. bipap orders for resident #39 were transcribed on 2/22/2018 2. a 100% audit of all residents on bipaps completed on 3/12/2018 to ensure order transcription. 3. Inservice training for Licensed	4/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING _____ B. WING _____	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 695

Continued From page 74

Findings include:

R 39 was admitted to the facility 9/19/17 with diagnoses to include, but not limited to: chronic respiratory failure, COPD, bronchiectasis (chronic dilation of the bronchi), anxiety, depression, and epilepsy.

The most recent MDS (minimum data set) was a quarterly review dated 12/14/17 and had R 39 coded as cognitively intact with a total summary score of 15 out of 15.

On 2/20/18 during a resident interview beginning at 3:18 p.m. R 39 commented to this surveyor "My BiPAP machine here has been broken for about two weeks; the people here have looked at it, and I think the nurses have tried to call the company but I guess they're having a hard time getting in touch with them; you know how that goes! I hope I get it fixed pretty soon, though; since I haven't been able to use it I'm not sleeping very well and I sleep later than I want to because of that."

On 2/21/18 at approximately 2:00 p.m. during review of the clinical record, it was noted the February 2018 POS (physician order summary) did not include orders for R 39's BiPAP machine.

On 2/21/18 at 3:40 p.m. The DON (director of nursing) and the regional nurse consultant were interviewed about R 39's BiPAP machine. The DON stated "It's not broken. The current machine in use just doesn't have a pressure setting high enough for her due to her disease; for that reason, she thinks it's broken. We have been in touch with the company and we are getting her a new one which should be here soon.

F 695 (Plan of Correction)

Nursing Staff initiated on 3/8/2018 by facility DON or designee regarding physician order transcription for bipaps. A weekly audit of all residents on bipaps to be completed by DON or designee for a period of 30 days to ensure order transcription.

4. The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 75 She does refuse to wear it at times. There was a consult dated 12/28/17 about resuming her BiPAP use, but it looks like the orders were signed off by nursing but not transcribed to the 'batch' orders to be on the POS. There should be orders on the POS." On 2/22/18 during a meeting with facility staff beginning at 7:44 a.m. the administrator and DON were informed of the above findings. During the meeting the DON gave this surveyor a copy of physician orders for the BiPAP machine use, including the settings and care of the machine. No further information was provided prior to the exit conference.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		4/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 76 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview and clinical record review, the facility staff failed to ensure medications were available for administration for one of 32 residents in the survey sample, Resident # 92. The facility staff failed to ensure Lispro (an intermediate acting) insulin and Sensipar (used to treat patients with chronic kidney disease who are on dialysis and is also used to treat high levels of calcium in the blood of patients with certain parathyroid gland problems) 30 mg (milligrams) tablets were available to Resident # 92 Findings include: Resident # 92 was admitted to the facility on 06/26/17. Diagnoses for Resident # 92 included, but were not limited to: End stage renal disease (dependent on renal dialysis), DM (diabetes mellitus), chronic kidney disease, long term (current) use of insulin, secondary hyperparathyroidism of renal origin, and dementia.	F 755	1) Lispro and Sensipar are now available for resident #92. 2) A 100% audit of all residents with orders for Lispro and Sensipar was completed on 3/14/2018 to ensure availability. 3) Inservice training of Licensed Nursing Staff initiated on 3/8/3018 by DON or designee regarding medication availability and protocol. A weekly audit of all residents with orders for Lispro and Sensipar to be completed by DON or designee for a period of 30 days to ensure availability. 4) The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755		F 755		

Continued From page 77

On 02/21/18 (Wednesday) at approximately 8:20 a.m. a medication pass and pour observation was in progress with LPN # 20. The LPN was preparing medications for administration for Resident # 92.

LPN # 20 stated that Resident # 92 was to get 9 units of Lispro insulin at this time. The LPN looked for the medication on the medication cart and in all of the drawers and could not find the medication to administer. The LPN then stated that the resident also gets a Sensipar 30 mg tablet on MWF (Monday, Wednesday, Friday) on dialysis days and that the resident did not have this medication either. The LPN stated that the resident had not had the medication for possibly a week and that it had something to do with insurance. The LPN then stated that she would go down to the medication closet at the end of the hall and look for both medications. This surveyor followed the LPN to the medication closet. The LPN looked all around in the room and in the refrigerator and did not find either medication.

The LPN administered all medications available for Resident # 92, excluding the Sensipar 30 mg tablet and the Lispro insulin 9 units. The resident was eating breakfast in his room at this time.

At approximately 8:45 a.m., a medication reconciliation was completed for Resident # 92.

Resident # 92's current POS was reviewed and included an order for, "..Insulin Lispro Give 9 units with breakfast and give 5 units with lunch and dinner HOLD for glucometer less than 150" and also had an order for "Sensipar tablet 30 mg Give one tablet by mouth one time a day every

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 78	F 755		

Monday, Wednesday and Friday for dialysis days." Neither of these medications were administered to Resident # 92. The LPN stated that the insulin had to be ordered from the pharmacy and that she thought it had been ordered. The LPN was asked when ordered medications is that done on the computer or on paper. The LPN stated that it can be done either and that she could look it up in the computer.

The LPN opened the computer and located that the Lispro insulin had been ordered on the 19th (Monday-2 days ago), it could not be determined who ordered the medication. The LPN then went to another screen and it documented that the insulin had been delivered on the 20th, but it was a different insulin, not the Lispro. The LPN stated that she didn't know for sure and would call the pharmacy and get the insulin ordered. The LPN was asked to find this surveyor if the medications are administered.

On 02/21/18 at approximately 2:45 p.m. LPN # 20 was interviewed regarding Resident # 92's insulin. The LPN agreed that she did not test Resident # 92's glucose reading this morning and did not administer the 9 units of insulin as ordered by the physician. The LPN did state that the DON (director or nursing) had got an order for the morning insulin to be held and that she (LPN) checked the resident's blood sugar at noon and it was 245 and that she administered the insulin at that time. The LPN couldn't explain why Resident # 92's Lispro insulin was not available for administration or why the Sensipar 30 mg tablet was not available for administration.

The resident's MARs (medication administration records) were then reviewed and documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 755 Continued From page 79 — F 755

that the resident had not received the Sensipar 30 mg tablet and had missed a total of four doses.

The resident's CCP (comprehensive care plan) was reviewed and documented, "...at risk for complications of diabetes mellitus...administer medications as ordered by doctor...chronic kidney disease...give medications as ordered. Observe for side effects..."

On 02/22/18, the administrator and DON (director of nursing) were made aware of the above information and concerns related to the medication errors the resident not receiving physician ordered medication. The DON stated that she obtained an order to hold Resident # 92's insulin for the missed dose (this morning) and stated that it (the insulin) had been resumed.

No further information and/or documentation was presented prior to the exit conference on 02/23/18 at 12:45 p.m.

F 759 SS=D — Free of Medication Error Rts 5 Prcnt or More — F 759 — 4/4/18
CFR(s): 483.45(f)(1)

§483.45(f) Medication Errors.
The facility must ensure that its-

§483.45(f)(1) Medication error rates are not 5 percent or greater;
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to ensure a medication error rate of less than 5% during the medication pass and pour observation. The facility had 5 medication errors out of 29

Plan of correction:

1) Medication error forms completed on all medication errors on 2/23/2018 and MD and RP notified of med errors. Resident #12, 345, and 92 had no adverse effects of medication errors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 759

Continued From page 80

opportunities, which resulted in a medication error rate of 17.24%.

The facility staff failed administer the following medications according to the physician's orders: Resident # 12 was ordered to have Seroquel 50 mg and the nurse administered Seroquel 25 mg; Resident # 345 was administered 10 units of insulin, when the resident's blood sugar was below the parameters for administration; Resident # 92 was not administered insulin with his breakfast (due to the medication not being available), was not administered Sensipar 30 mg (due to the medication not being available) as ordered by the physician and a glucose reading was not taken.

Findings include:

On 02/21/18 (Wednesday) at approximately 8:00 a.m. a medication pass and pour observation was conducted with LPN # 20.

LPN # 20 prepared morning medications for Resident #12. One of the medications dispensed into the plastic medication cup for Resident # 12 was a Seroquel 25 mg (milligrams) tablet. The resident was administered the medications without difficulty.

At 8:10 a.m., LPN # 20 then prepared medications for Resident # 345. The LPN checked the resident's blood glucose level, which read 115 on the meter. The LPN then took an insulin syringe and pulled up 10 units of Novolog Aspart and administered the medication in the resident's left arm. The resident was eating breakfast in his room, at the time of insulin administration.

F 759

2) All residents have the potential to be at risk for medication errors.
3) LPN #20 Inserviced by DON on 3/18/2018. Inservice training for Licensed Nursing staff was initiated on 3/8/2018 by DON and designee regarding proper medication pass procedure. A weekly audit of 3 medication passes to be completed by DON or designee for a period of 30 days to ensure medication error rate is less than 5%.
4) The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 81	F 759		

At 8:20 a.m., LPN # 20 then prepared medications for Resident # 92. The LPN stated that the resident is supposed to get Sensipar 30 mg on dialysis days MWF (Monday, Wednesday, Friday). The LPN looked for the medication and stated that the medication was not available for administration. The LPN then stated that the resident receives 9 units of insulin (Lispro) with meals. The medication could not be located on the medication cart or in the supply closet down the hall. The LPN administered all medications available for Resident # 92, excluding the Sensipar 30 mg tablet and the Lispro insulin 9 units. The resident was eating breakfast in his room at this time.

At approximately 8:40 a.m., a medication reconciliation was completed for Resident # 12. Resident # 12's current POS (physician's order set) included an order for, Seroquel tablet 50 mg Give 50 mg by mouth two times a day (started 12/14/17) and an order for Seroquel tablet Give 75 mg by mouth at bedtime (started on 02/13/18). Further review of Resident # 12's physician's orders revealed that the resident had a previous order (now discontinued) for Seroquel 125 mg (100 mg plus 25 mg to equal 125 mg) that was ordered on 12/20/17 and was discontinued on 01/30/18.

LPN # 20 was interviewed regarding the above information for Resident # 12. The LPN was asked to pull out all of Resident # 12's medication cards. The LPN removed all the medication cards for the resident and had three cards for Seroquel, all of which medication had been removed from. The first card was for Seroquel 50 mg twice daily, the second card was for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759		F 759		

Continued From page 82
Seroquel 100 mg to be given each night, with the third card of Seroquel 25 mg to be given with the 100 mg tablet to equal 125 mg each night. The LPN was asked to look at the physician's order for Resident # 12 on the computer screen, the LPN looked at the computer and for the Seroquel, the resident had an order for 50 mg of Seroquel twice daily and an order for Seroquel 75 mg each night, then stated that (order) has changed and that she did not realize that the Seroquel 125 mg had been discontinued and that there were three Seroquel medication cards (25 mg, 50 mg, 100 mg) for Resident # 12 available for administration. The LPN stated that she must have pulled the 25 mg tablet of Seroquel instead of the 50 mg tablet of Seroquel.

A medication reconciliation was completed for Resident # 345. The residents current POS (physician's order set) included an order for, "Novolog Flex Pen Solution Pen-injector Inject 10 units subcutaneous two times a day...IF BLOOD SUGAR LESS THAN 150, HOLD INSULIN." The resident's MAR (medication administration records) were then reviewed and documented that the resident would receive 10 units of Novolog Aspart insulin at 8:00 a.m. and 12 noon each day and if the blood sugar was less than 150, to hold the insulin.

The LPN was asked if she could pull Resident # 345's orders for insulin up to review. The LPN was asked about the Resident's insulin pen and was asked why a syringe was used instead of the flex pen. The LPN stated that the resident did not have one. The LPN was asked to read the physician's order regarding holding the insulin if the blood sugar was less than 150. The LPN was asked what Resident # 345's blood sugar was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 83 and the LPN stated, 115 and it should have been held. The medication reconciliation for Resident # 92 was completed. Resident # 92's current POS was reviewed and included an order for, "..Insulin Lispro Give 9 units with breakfast and give 5 units with lunch and dinner HOLD for glucometer less than 150" and an order for, "Glucometer check before meals hold insulin if blood sugar less than 150." LPN # 20 was interviewed regarding Resident # 92's insulin. The LPN did not test the resident's glucose reading that morning and did not administer the 9 units of insulin as ordered by the physician. The LPN stated that she had checked the resident's blood at approximately 11:45 a.m. and that the resident's blood sugar was 245 and he was administered insulin at 12:25 p.m. The LPN stated that the medication was not available for administration at 7:30 that morning during the medication pass and pour observation. The LPN was then asked about the resident's Sensipar 30 mg tablet had not been available for about a week and that it had something to do with insurance. On 02/22/18, the administrator and DON (director of nursing) were made aware of the above medication errors and the medication error rate of 14.81 %. The DON stated that for Resident # 92, the facility got an order to hold the insulin for missed dose and stated that it (the insulin) resumed that day at lunch. No further information and/or documentation was presented prior to the exit conference on 02/23/18 at 12:45 p.m.	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on a medication pass and pour observation, staff interview and clinical record review, the facility staff failed to ensure one of 32 residents was free from a significant medication error, Resident # 345. The facility staff administered 10 units of fast acting insulin (Novolog Aspart) to Resident # 345 for a blood glucose level of 115; the facility staff failed to follow specific physician ordered parameters for insulin administration when the resident's blood sugar was less than 150. Findings include: On 02/21/18 (Wednesday) at approximately 8:00 a.m. a medication pass and pour observation was started with LPN # 20. At approximately 8:10 a.m., LPN # 20 then prepared medications for Resident # 345. The LPN stated that the resident received 10 units of insulin every morning and proceeded to check the resident's blood glucose level. The blood sugar reading was 115. The LPN then took an insulin syringe and pulled up 10 units of Novolog Aspart and administered the medication in the resident's left arm. A medication reconciliation was completed for Resident # 345. The residents current POS	F 760	1) Medication error form completed on 2/23/2018 for med error on resident #345 and MD and RP notified. Resident #345 had no adverse reaction from significant med error. 2) All residents are at risk for a significant med error. 3) LPN #20 Inserviced by DON on 3/18/2018. Inservice training for Licensed Nursing staff was initiated on 3/8/2018 by DON and designee regarding proper medication pass procedure. A weekly audit of 3 medication passes to be completed by DON or designee for a period of 30 days to ensure residents are free of significant medication errors. 4) The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.	4/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING ______ B. WING ______	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 760	Continued From page 85	F 760		

(physician's order set) included an order for, "Novolog Flex Pen Solution Pen-injector Inject 10 units subcutaneous two times a day...IF BLOOD SUGAR LESS THAN 150, HOLD INSULIN." The resident's MAR (medication administration records) were then reviewed and documented that the resident would receive 10 units of Novolog Aspart insulin at 8:00 a.m. and 12 noon each day and if the blood sugar was less than 150, to hold the insulin.

LPN was interviewed on 02/21/18 at approximately 2:45 p.m., the LPN was asked if she could pull Resident # 345's orders up on the computer for insulin to review. The LPN was asked about the Resident's insulin pen and was asked why a syringe was used instead of the flex pen. The LPN stated that the resident did not have one. The LPN was then asked to read the physician's order regarding holding the insulin if the blood sugar was less than 150. The LPN was asked what Resident # 345's blood sugar was for this morning and the LPN stated, 115 and it should have been held and further voiced that the resident was eating his breakfast at the time.

Further review of Resident # 345's MAR (medication administration records) revealed that the resident was administered 10 units of Novolog Aspart (fast acting insulin) on multiple occasions when the resident's blood sugar was below the physician's parameters of 150.

The following dates and times are listed with the resident's blood glucose (sugar) level below 150 and the resident was still administered a fast acting (Novolog Aspart) insulin of 10 units each time.

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	495151	A. BUILDING ____ B. WING ____	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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F 760	Continued From page 86 02/02/18 8:00 a.m. blood sugar reading 132 02/05/18 8:00 a.m. blood sugar reading 121 02/08/18 11:30 a.m. blood sugar reading 123 02/12/18 8:00 a.m. blood sugar reading 122 02/13/18 11:30 a.m. blood sugar reading 94 02/14/18 8:00 a.m. blood sugar reading 99 02/16/18 8:00 a.m. blood sugar reading 126 02/17/18 11:30 a.m. blood sugar reading 132 02/18/18 11:30 a.m. blood sugar reading 132 02/20/18 11:30 a.m. blood sugar reading 125 02/21/18 8:00 a.m. blood sugar reading 115- medication pass/pour observation 02/22/18 11:30 a.m. blood sugar reading 122 On 02/22/18 at 4:30 PM the administrator and DON (director of nursing) were made aware of the medication errors for Resident # 345. The administrator and DON were made aware that Resident # 345 had not received his insulin as ordered by the physician. The administrator and DON were made aware of the significant medication error rate for Resident # 345. No further information and/or documentation was presented prior to the exit conference on 02/23/18 at 12:45 p.m.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		4/4/18

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F 812 Continued From page 87

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, and staff interview the facility failed to procure, serve and store food in a sanitary manner in the main kitchen.

Food was not labeled, debris was found in the flour and sugar bins, and the dietary manager (DM) removed the debris from the bins with ungloved and unwashed hands.

The Findings include:

02/20/18 10:15 AM Entered main kitchen for initial tour. A bin of thickener was not labeled, also bin of flour was not labeled. The bin of flour and bin of sugar had debris observed mixed in with the sugar and flour. The DM stuck ungloved and unwashed hand down in both bins and removed the debris. Prior to the DM putting his hands down into the bins the DM was touring with the surveyor handling inanimate objects (refrigerators, boxes, cans, dry goods) and did not wash hands prior to touching food.

On 2/20/18 at 12:00 PM an interview with the DM regarding concerns was conducted. The DM verbalized he was inappropriate and should have washed and used a glove to remove debris from

F 812

1. Identified food has been labeled. Flour and Sugar in bins that were identified with debris have been discarded.
2. All residents have the potential to be at risk by deficient practice.
3. Food services (food purchasing, food preparation and kitchen/dietary operations) are provided by an external contracted vendor. The District Manager for the Dietary Manager (DM) has been informed of this deficient practice. The District Manager has conducted a comprehensive in-service re-training on 3/9/2018 for the DM and the staff of the dietary department on approved policies and procedures with respect to labeling foods and food products, sanitation, Infection control practices including handwashing and safe food/food product handling. An audit of food storage areas will be conducted five times a week at various shift times for a period of 30 days by Dietary Manager to ensure food is properly labeled/contained/stored. A kitchen inspection will be conducted by Dietary Manager five times a week at

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F 812	Continued From page 88 bins. The DM also verbalized that the flour and sugar bins should have been labeled. The DM verbalized that after thinking about what he had done he removed the flour, sugar, and thickener from the bins. On 02/22/18 at 08:33 AM A meeting was held with the administrator and DON regarding flour, sugar, and thickener bins. The Administrator verbalized that the dietary manager should not have put his hands in the bins and the bins should have been tabled and also verbalized that the contents had been thrown out. No other information was presented prior to exit conference on 2/23/18.	F 812	various shift times for a period of 30 days to ensure gloves are utilized, hand washing protocol is followed and infection control/sanitation protocols are followed. The vendor District Manager or designee will make unannounced visits at least once a week for 4 weeks to observe and validate compliance with protocols on properly labeling/containing/storage of food/food , and, adherence to protocols of sanitation, infection control, handwashing and glove utilization. 4. The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		4/4/18

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F 880	Continued From page 89	F 880		

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or
infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

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F 880	Continued From page 90 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to follow infection control practices for infection surveillance. The facility's infection control tracking system failed to include tracking by specific organism so that potential care related infections could be identified. The findings include: On 2/22/18 at 2:37 p.m., accompanied by the infection control coordinator, the facility's infection control policies and tracking were reviewed. The monthly infection surveillance logs had spaces for resident names, type of infections, a designation for in-house infections, identified infectious organisms, current treatments, control techniques including isolation and date resolved. With the exception of December 2017, monthly tracking logs reviewed from September 2017 through February 2018 failed to indicate the type and description of the infection, if infections were acquired "in-house," the identified infectious organism, if isolation or other control techniques were used or the date resolved. Logs for September 2017, October 2017 and November 2017 listed only resident names, room numbers and antibiotics used. The other designated categories were blank. The January 2018 log	F 880	1) Facility infection control tracking system has been modified to now include the tracking of specific organism so that potential care related infections can be identified. 2) All residents have the potential to be at risk 3) Facility Infection Control Nurse was inserviced on 3/14/2018 by Director of Nursing regarding tracking of specific organism so that potential care related infections can be identified. A weekly audit facility infection control tracking system by facility DON or designee to be completed for 30 days to ensure tracking mechanisms include tracking of specific organisms. 4) The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.	

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F 880		F 880		

Continued From page 91
was missing identified organisms and date resolved. The February 2018 tracking log included no infectious organisms, no control techniques used or dates resolved.

The infection control coordinator was interviewed on 2/22/18 at 2:37 p.m. about the missing tracking data. The coordinator stated he was new to the facility and did not have access yet to the laboratory database in order to obtain information the specific infectious organisms. The coordinator stated he did not know why the categories and tracking data were not completed as listed on the logs.

The facility's policy titled Infection Control (effective 9/20/17) stated, "It is a policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections....A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards..."

The Center for Disease Control's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings states concerning surveillance, "...Monitor adherence to infection prevention practices and infection control requirements...Provide prompt, regular feedback on adherence and related outcomes to healthcare personnel and facility

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F 880	Continued From page 92 leadership...Monitor the incidence of infections that may be related to care provided at the facility and act on the data and use information collected through surveillance to detect transmission of infectious agents in the facility..." (1) These findings were reviewed with the administrator and director of nursing during a meeting on 2/22/18 at 5:25 p.m. (1) Core Practice Table. Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings. Updated March 2017. CDC. 2/26/18. https://www.cdc.gov/hicpac/recommendations/core-practices.html	F 880		